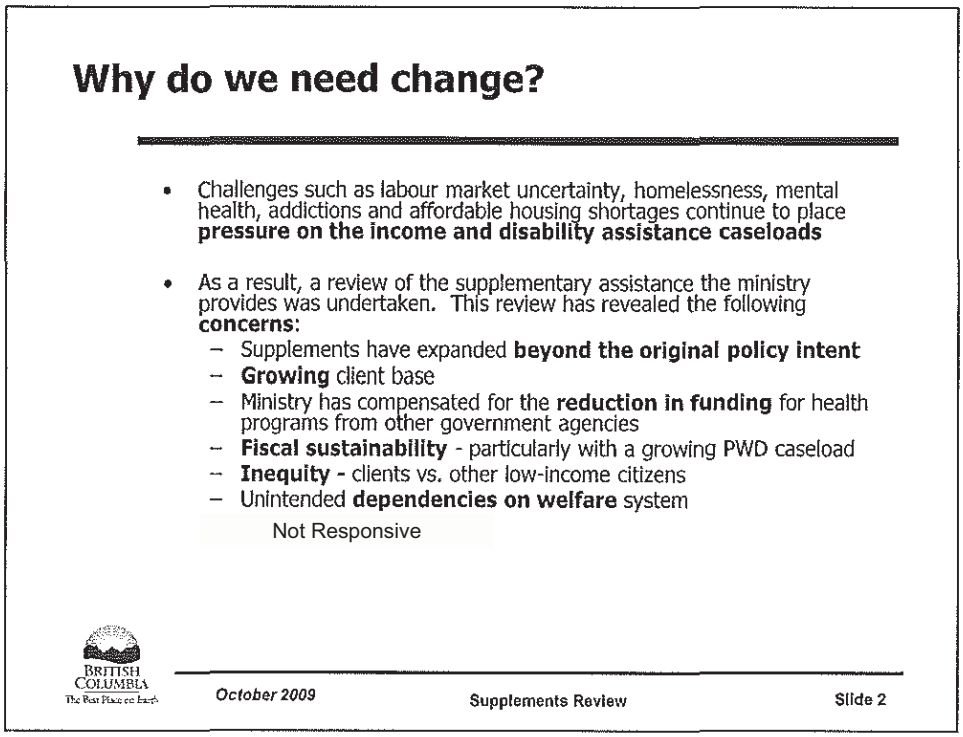
Ministry of Housing and Social Development

Supplements Review
Presentation to the Deputy

October 2009

BRITISH COLUMBIA
The Best Place on Earth



Expanding beyond policy intent and growing client base –

MNS - from catastrophic medical conditions at end stage to chronic, manageable conditions
MSO – from (time-limited) transitional benefit to one that is ongoing

Inclusion of more "former" clients groups i.e.: grandparented seniors with enhanced medical, AYA & CVA

Medical Equipment and Supplies

Broad regulatory language has resulted in moving away from providing basic items

linclusion of technological advances (power wheelchairs, scooters and orthotics)

Reduction of funding available through other govt agencies

Medical equip for clts in MHS facilities, eye exams for adults under 65

Increase of persons with disabilities in the community rather than in LTC hospitals

Pressures to continue to expand (i.e.: coverage of rxs. not covered by Pharmacare)

Inequity and dependencies of welfare

clts on assistance have access to health supplements where other low-income citizens do not

Not responsive

Supporting Strategic Shifts

- **Refocus to support principles of**
  - Self-reliance and Personal Responsibility
  - Fiscal Sustainability
  - Social and Labour Market Inclusion
  - Program of Last Resort
- **Positions supplements to where they can support future strategic shifts**
  - Focus supplements to meet basic needs
  - Incentives based on client meeting conditions and outcomes
  - Make the provision of health related items more consistent and equitable across government

Limited resources are directed those most in need

Supplements linked to support employment, where appropriate

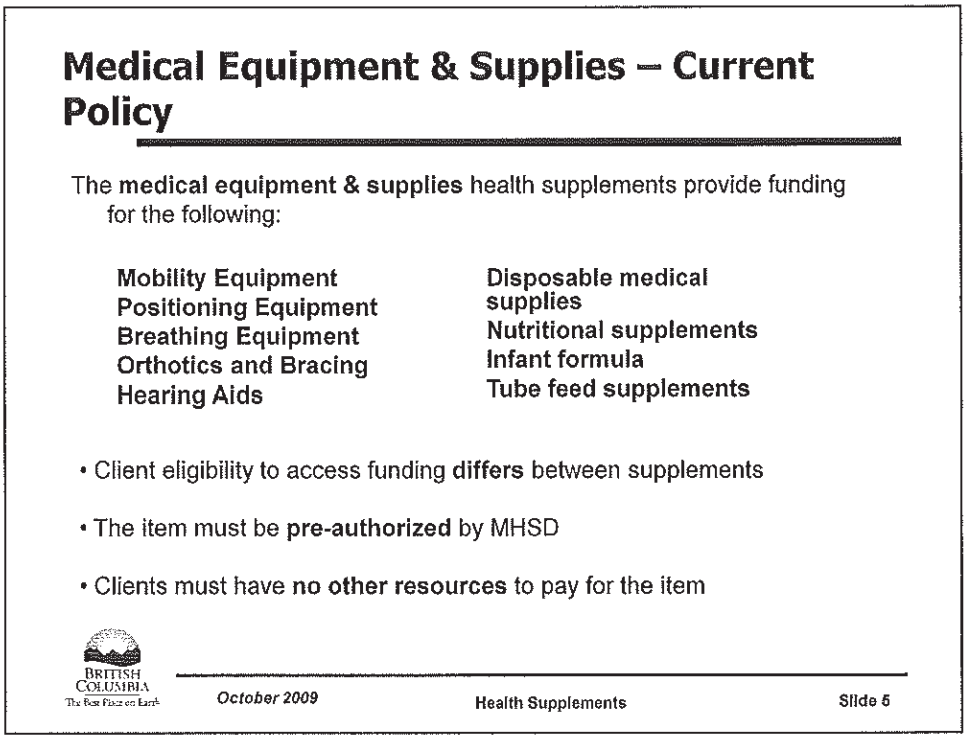
Continued support for PWD clients moving to employment

s.13

Overview of Supplements Review

This presentation is focused on the following Supplements:

- Medical Equipment
- Medical Supplies
- Monthly Nutritional Supplement (MNS)
- Medical Services Only (MSO)
- Life Threatening Health Need (LTHN)
-
- Not Responsive
-



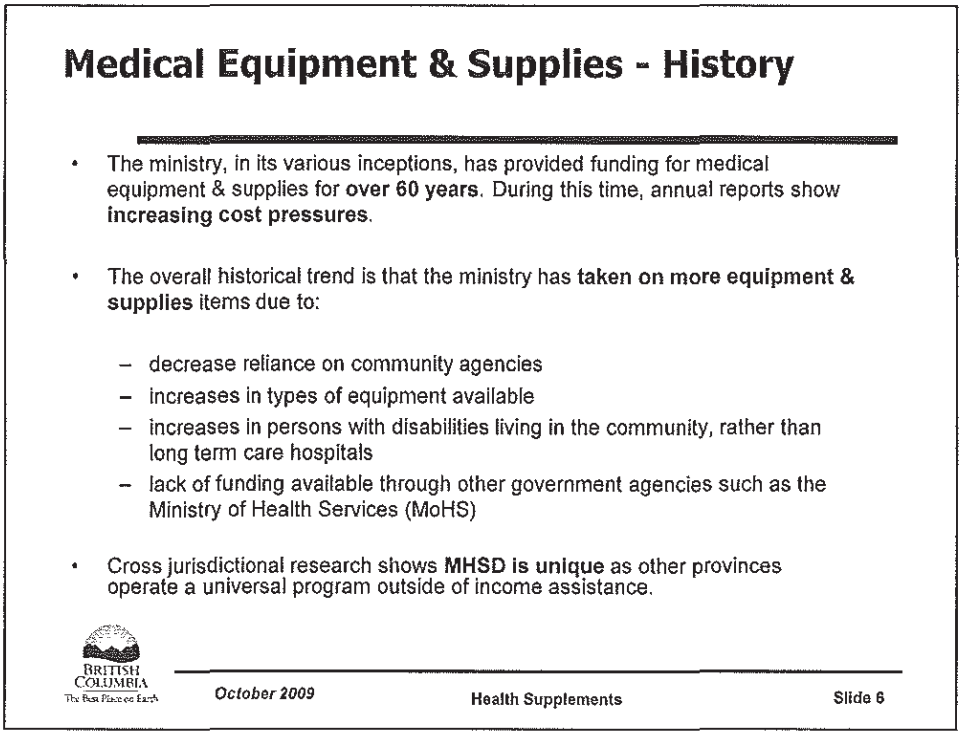
Additional info:

•Hearing Aids not in scope of health supplements review due to recent streamlining changes in 2007 and 2008 – removal of two quotes, decibel level, increased EAW spending authority. 08/09 expenditures: 1.7M, 07/08 expenditures: 1.3M

•PWD clients are the primary client group that access these supplements

•Mobility equipment is the only one that specifically lists in regulation what can be considered: canes, crutches, walkers, wheelchairs, personal motorized mobility devices (scooters)

•MHSD is considered the "payer of last resort"



Additional history info:

•Lack of funding available example: the tube feed supplement was added in 2008 and infant formula and nutritional supplements in the early 2000's.

Additional jurisdiction info:

•The general BC population only has access to these medical equipment items if they have a life threatening health need. The MoHS provides some items but with limited access, such as some orthotics items for children only.

•All Albertans and Ontarians have access to these health supplements and are required to pay a portion of the cost based on their income. Generally, the cost share ratio is 75 percent for the province and 25 percent for the individual. If a person is on an income/disability assistance type program, that program will pay their portion.

•Ontario and Alberta's income/disability assistance programs still end up funding some equipment not funded by their respective programs available to the general public.

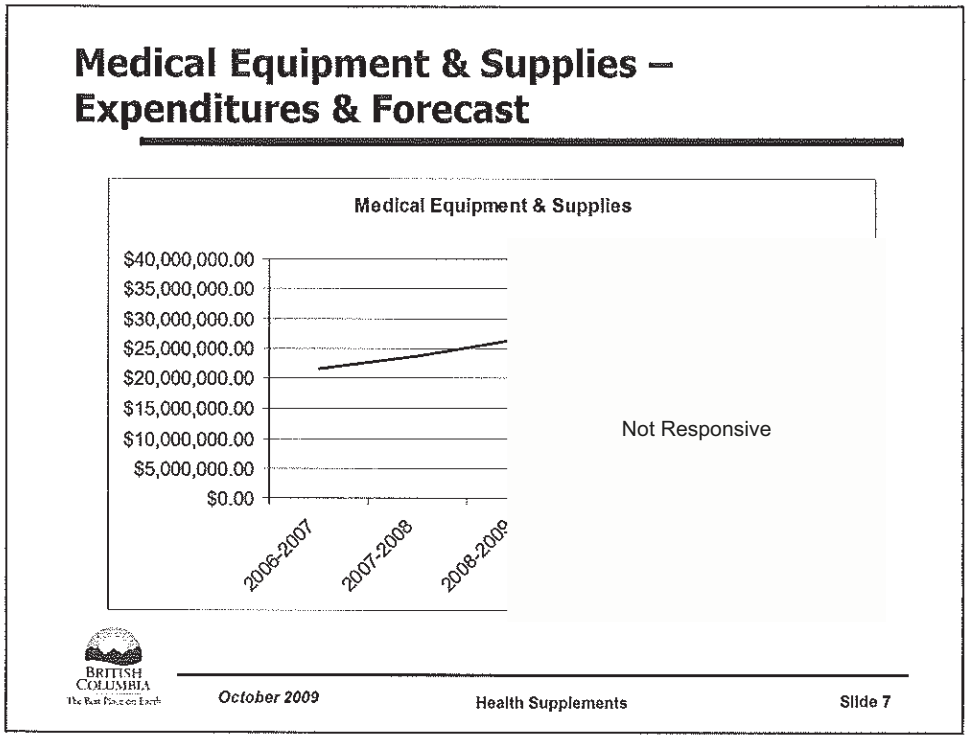
Differences in items funded:

•Alberta Aids to Daily Living does not fund CPAP machines, foot orthotics, or scooters. However, Alberta AISH funds CPAP.

•Ontario Assistive Device Program funds CPAP and scooters but not foot orthotics, hospital beds, bathing/toileting aids, or lifting devices.

•Ontario and Alberta do not fund infant formula or comparable nutritional supplements.

•Ontario and Alberta fund tube feed but through health or community supports type ministries



Why the increase in expenditures?

•Describe individual charts

•Appears to be a result of the increasing number of client access, particularly Persons with Disabilities

•Shifts in ministry direction since 2006, including:

- •Policy and regulation amendments to increase access for clients (e.g. increasing access to health professionals for assessments)
- •Reducing documentation required such as the new medical supplies review policy in 2006
- •Broadening "basic mobility" interpretation
- •The disability strategy
- •Client centered service delivery
- •Introducing the tube feed supplement in 2008

Misc. info:

•Expenditures in blue, forecast in blue dashes

•Changes in STOB reporting in March 2006 prevent a five year comparison for mobility/positioning/breathing.

•Expenditures for supplies, nutritional, infant formula, and tube feed are grouped together as "medical supplies" for budgetary purposes

<u>Medical Equipment</u> CAT Data Trend Analysis – 04/05 to 08/09

Average Cost per Client

Mobility/positioning: 10 percent increase

Breathing: 17 percent decrease

Orthotics and bracing: 24 percent increase

Average Cost per Item

Mobility/positioning: 3 percent increase

Breathing equipment: 24 percent decrease.

Orthotics and bracing:18 percent increase

Increasing Client Access

•Mobility/positioning: 79 percent increase (1,478 to 2,648)

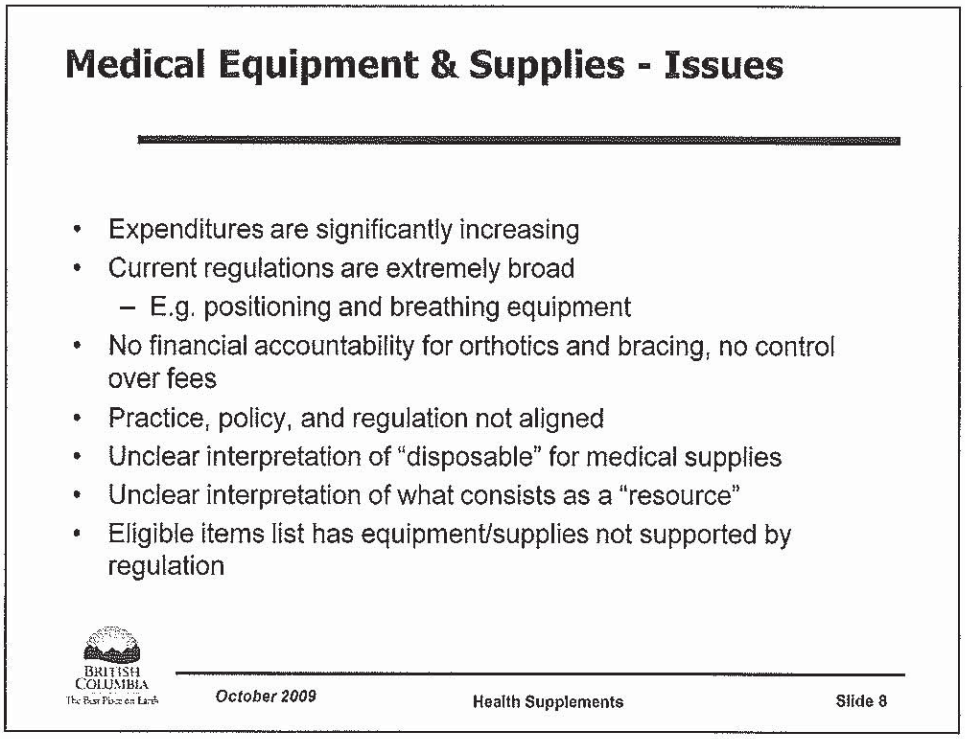
•Breathing: 241 percent increase (275 to 938)

•Orthotics/Bracing: 43 percent (2,309 to 3,295)

•The number of items funded per client increased on average 11 percent for all equipment.

•About 75% of clients accessing equipment are PWD

•PWD cases accessing medical equipment are increasing faster than the growth of the PWD caseload. It would be expected that as the PWD caseload grows, the proportion of PWD cases accessing medical equipment would remain constant; however, this has not been the case.



•Issues list developed in consultation with Provincial Services and Regional staff

Examples:

Disposable

Medical Supplies criteria includes the word "disposable" and excludes bottled water, nutritional supplements, food, and vitamins or minerals. This has led to interpretation of prescription drugs as they are "disposable" and not specifically excluded. There is no direction to staff or clients on what the ministry considers "disposable." Further, "disposable" restricts MHSD from providing reusable items that are more cost effective and better for the environment.

Medical Supplies Criteria:

(a) **disposable** medical or surgical supplies other than bottled water, nutritional supplements, food, vitamins or minerals, if

(i) the supplies are

(A) prescribed by a medical practitioner or nurse practitioner,
(B.C. Reg. 317/2008)

(B) used in a medical procedure or treatment, and

(C) necessary to avoid an imminent and substantial danger to health, and

(ii) there are no resources available to the family unit to cover the cost of the supplies;

Resource

Currently, there are no guidelines available to ministry staff regarding what is considered a "resource." Clients are not consistently assessed whether they have other resources available to pay for the item. Resources can vary from cash available to the family unit to other funding sources such as ICBC or MoHS if the client is living in a MoHS funded facility. The ministry currently does not require clients to access trusts for health supplements, including medical equipment.

Medical Equipment & Supplies – Recommended Options

Amend eligibility criteria in regulation to focus on providing the most basic and least costly items

- Eliminate s.13 off the shelf shoes, and s.13
- List specific items in regulation that are considered "positioning devices," "breathing devices" and "medical supplies"
- Develop basic medical criteria for positioning and breathing equipment
- Allow reusable medical supplies where appropriate

- Supports MoHS alignment to provide basic, lower cost items
- Perception of changes not in support of the disability strategy
- Negative reaction from clients, health professionals, and the advocacy community s.13
- Providing re-usable supplies will lower long term costs (reducing repeat requests)

BRITISH COLUMBIA The Best Place on Earth

October 2009 Health Supplements Slide 9

Further justification for eliminating items:

Foot orthotics/shoes

•People affected (FO's): 08/09 approvals = 1844

•People affected (Shoes): 08/09 approvals = 792

•There is debate in the media whether foot orthotics are truly required in some circumstances or if service providers recommend them to increase profits. As a result, some private insurance companies have limited certain types of foot orthotics or restricted the professionals that can provide them.

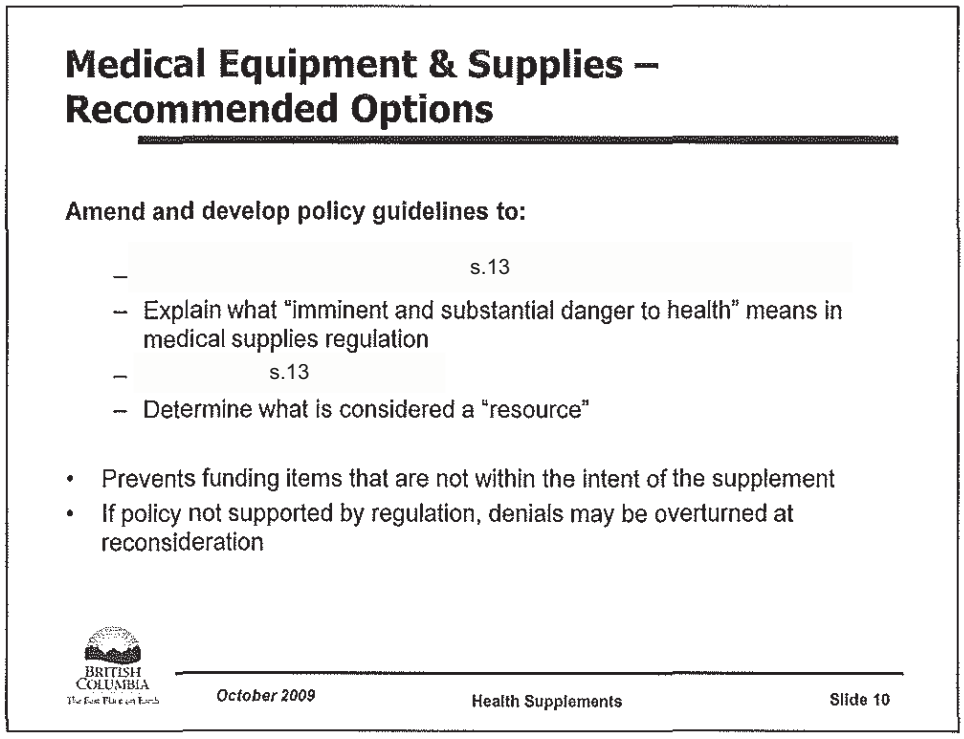
•Pharmacare, Alberta, and Ontario do not provide foot orthotics.

•Off the shelf shoes are provided for clients that need accommodation for foot orthotics. However, off the shelf shoes are not an orthotic or brace and s.13

•Custom shoes will continue to be available for those clients with severe foot conditions s.13

s.13

CPAP: 798 approvals in 08/09



Additional resources info

•First step is to create the guidelines in policy, then evaluate whether they should be in regulation.

•Guidelines will be a tool for staff on what should be considered a resource (resources may differ depending on the supplement and client type)

•In order to address clients in MoHS facilities, a separate project will follow to determine what health supplements they should receive (if any).

Medical Equipment & Supplies – Recommended Options

Develop a regulated schedule of items for orthotics/bracing, mobility, positioning, and breathing

- Supports greater adjudication efficiency and fiscal accountability
- Supports a base for further contract opportunities

Increase procedural efficiencies

s.13

- Stop paying for non-regulatory items e.g. TENS machine, contraceptive devices
- Revise applicable forms

s.13

Not Responsive

BRITISH COLUMBIA

October 2009 Health Supplements Slide 11

Additional Implications:

•Implementation of changes to spending authority may be delayed until staff impacts of other changes are determined.
•Estimated systems costs: N/A

Overall recommendations:

•Status quo for nutritional supplements, infant formula, and tube feed - consultation with HAB revealed no major regulation or policy issues

s.13

Not Responsive

Medical Equipment & Supplies – Not Recommended Options

s.13

Monthly Nutritional Supplement – Current Policy

The **Monthly Nutritional Supplement (MNS)** provides a monthly monetary supplement to PWD clients with a severe medical condition which is causing a chronic, progressive deterioration of health resulting in wasting symptoms.

The supplement is intended to prevent an imminent danger to the person's life by providing essential items to alleviate the identified wasting symptoms. MNS is provided in three components:

- **nutritional items** that are part of a caloric supplementation to regular dietary intake **($165)**,
- **bottled water** if suffering moderate to severe immune suppression **($20)**, and
- **vitamins/minerals ($40)**

BRITISH COLUMBIA
The Best Place on Earth

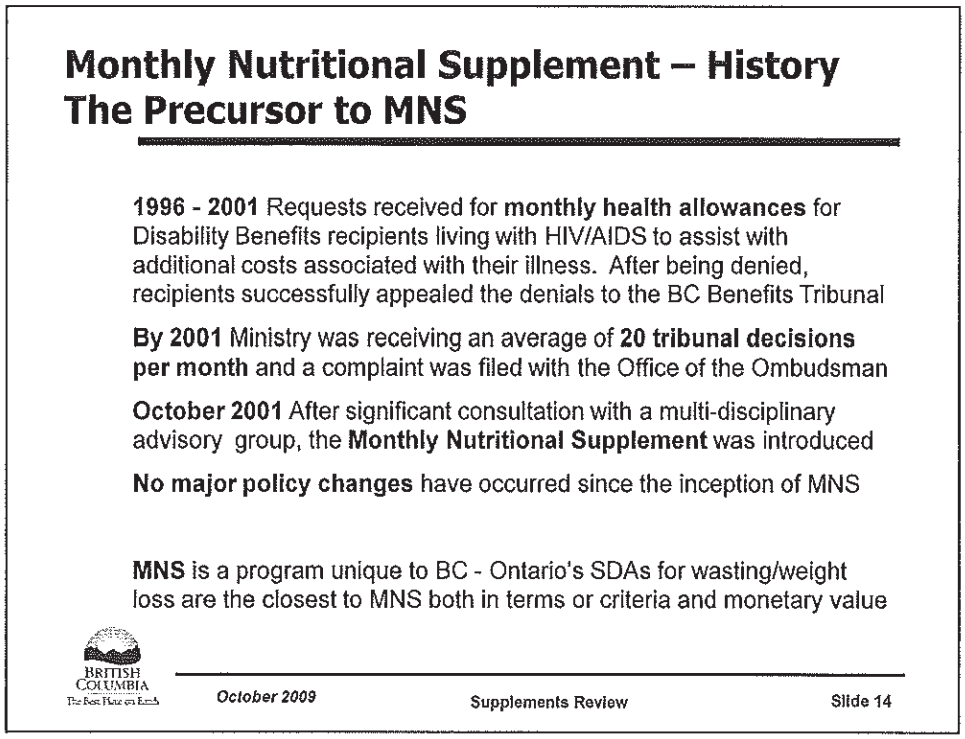
October 2009 Supplements Review Slide 13

Wasting symptoms - the person displays one or more of the following symptoms:

malnutrition
underweight status
significant weight change
muscle mass loss
bone density loss
neurological degeneration
significant deterioration of an organ
moderate to severe immune suppression

PWD clients may apply for any one or all of the components by having their medical or nurse practitioner complete the Application for MNS form (HSD2847)

MNS was designed as monetary supplement for the purposes of allowing recipients the ability to purchase the items they require. In many cases, this items include food items – additional vegetables, fruits, protein, dairy products, etc. Vitamins and minerals – a wide array.



Legal authority used for these monthly health allowances was **Schedule C, s.2 (1) (l)** of the Disability Benefits Program regulation.

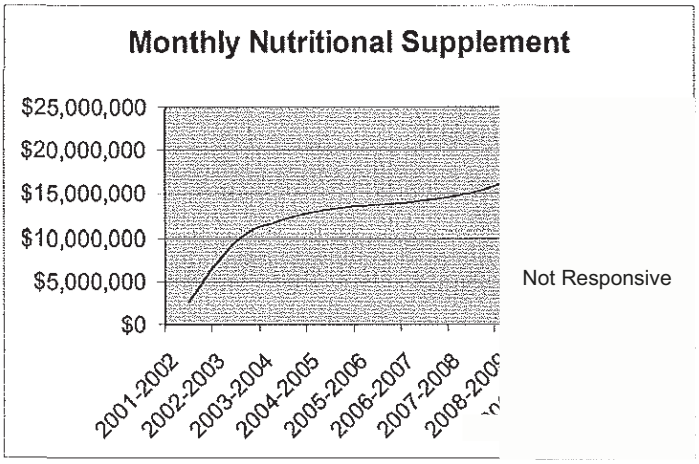
This was a special clause that allowed the ministry to provide any health care good or service not provided elsewhere to anyone with a "life-threatening need" for which "no other source of funding was available".

The subject of the ombudsman complaint lodged by the BCPWA Society was alleging misuse of the appeal system to resolve client requests for monthly cash health allowances.

Requests and awards typically included funding for the additional costs associated with a nutritional diet, vitamins, minerals and bottled water. However, some requests and awards expanded to include over the counter medication, a wide variety of complementary therapies and even items such as health club memberships, pet care and car insurance. Over time, award amounts steadily increased (from $200 to over $429)

- **Ontario**'s Special Diet Allowances (SDA) for medical conditions that result in **wasting/weight-loss** are the closest to MNS both in terms of criteria and monetary value.
  - Restricted to 13 conditions related to wasting/weight loss
  - Amount provided is based on % of weight loss ($75-$240)
  - Changed SDA to a diagnosis based system in 2005

Monthly Nutritional Supplement – Budget & Expenditures



BRITISH COLUMBIA
The Best Place on Earth

October 2009 Supplements Review Slide 15

Trend analysis - Expenditures continue to grow year over year

2001/02	**$2.6M (Oct 1 – Mar 31)**
2002/03	**$9.6M (first full year)**
2003/04	**$12.1M**
2004/05	**$13.2M**
2005/06	**$13.7M**
2006/07	**$14.3M**
2007/08	**$15.0M**
2008/09	**$16.7M** (expenditures exceeded budget by $700,000)

Not Responsive

MNS uptake

- Initial estimated uptake was **4,000 cases**
- FY 02/03 showed **5359** distinct cases
-Although MNS was initially designed to provide additional assistance for people with catastrophic illnesses who are near the end of their lives, the data does not support this view. Now, 6 to 7 years later, **60% of those original approvals are still in receipt of MNS (**
-FY 08/09 shows **8051** distinct cases - Average of 2500 receive all three codes (approx 1/3)

Since 2004/05, the percentage of PWD cases receiving MNS (**all codes combined**) has increased from 9.3% to 10.6% in 2008/09.

This shows that the proportion of PWD cases receiving MNS has remained relatively consistent over the last 5 years.

However, as the overall PWD caseload grew 26% during this 5 years, the result has been a significant rise in MNS cases and an increase in expenditures of $3.5 M.

Monthly Nutritional Supplement – Issues

- Current regulatory language
  - discretionary authority with medical practitioner
  - eligibility criteria too broad
- Application form does not support discretionary decision making
- Absence of review policy
- Conflicting opinions on benefits of bottled water
- Provided as cash not product
- Requests for MNS instead off or in the absence of appropriate diet supplement
- Expenditures are steadily increasing

Wasting symptoms in regulation allow for approval of MNS for conditions such as:

Lack of teeth (malnutrition - due to inability to chew) ***Tribunal***

Morbid Obesity (significant weight change - increase)

Osteoporosis (bone density loss – onset due to aging)

Absence of a review policy – inability to reassess clients who may have been approved for a short term need (aka cancer that has been treated/cured) or may no longer have a substantiated need. Physician's indicate 6 month need but no review done. - inequality – extra support funds that other clients do not have access to!!!

Many of these issues were identified in consultation with HAB and RB staff as part of a previous MNS review done during the 2005 budget initiative process. The recommendations were not implemented at that time due for political reasons.

Monthly Nutritional Supplement – Recommended Options

Amend MNS regulations, policy and procedures to support sustainability

- Ensure that decision making on whether the criteria have been met is with the minister
- Strengthen eligibility criteria (wasting symptoms)
- Support review policy

Not Responsive

- Amend the application form to use more open ended questions

- Aligns regulatory language with other EAPWD and health supplements
- Decreases the # of cases being approved that are outside the intent of MNS
- Application changes support the adjudication process – better quality information!
- Ombudsman and Advocates may perceive a review policy as contrary to previous ministry commitments to reduce medical documentation requirements

BRITISH COLUMBIA

October 2009 Supplements Review Slide 17

Risks

MNS reviews will increase HAB workload for the short term but this impact should be reduced over time as MNS caseload declines

Possible options to tighten wasting symptoms:

malnutrition

underweight status s.13

significant weight change (change to significant weight loss s.13

muscle mass loss (qualifiers – "significant" s.13

bone density loss (consider removing this symptom)

neurological degeneration

significant deterioration of an organ (specify to vital organs – excludes loss of eye, etc)

moderate to severe immune suppression

Not Responsive

Estimated @ % reduction:

5% - reduction of new starts discretionary reg and app changes

5% - initial review

2% - ongoing review policy

Monthly Nutritional Supplement – Recommended Options, cont'd

Eliminate bottled water – ALL cases

- Health Canada indicates that boiling tap water is an alternative approach as bottled water is not routinely monitored for parasites
- Potential health risk for moderate to severe immune suppressed clients due to lack of facilities and physical ability to boil water/store water
- Could be perceived as a rate cut ($20/month)
- Requires transition plan for clients currently receiving supplement

Not Responsive

Estimated systems costs: 28,000 - $42,000

Not Responsive

BRITISH COLUMBIA

October 2009 Supplements Review Slide 18

Eliminate bottled water ALL:

Not Responsive

Client impact – 3840 clients received bottled water in 08/09 (Mars data)

•Supports the environmental concerns regarding the use of disposable containers

Monthly Nutritional Supplement – Options Not Recommended

s.13

Monthly Nutritional Supplement – Options Not Recommended

s.13

MSO – Current Policy

MSO is available to PWD clients who leave assistance for:

- employment
- under age 65 leaving for federal income support
- OAS/GIS (at age 65)
- the MCFD's Agreements with Young Adults (AYA) and Crime Victims Assistance (CVA)
- CPP mediated class action settlement

MSO is also available to PPMB clients who leave assistance for:

- OAS/GIS (at age 65)
- CVA
- CPP mediated class action settlement

Regulation: Medical supplies, equipment, dental, optical, eye exams, extended therapies, medical transportation and tube feeds (if in receipt at time of transition)

Policy: MSO allows premium free MSP and no deductible Pharmacare. Policy excludes medical transportation

BRITISH COLUMBIA
The Best Place on Earth

October 2009 **Health Supplements** **Slide 21**

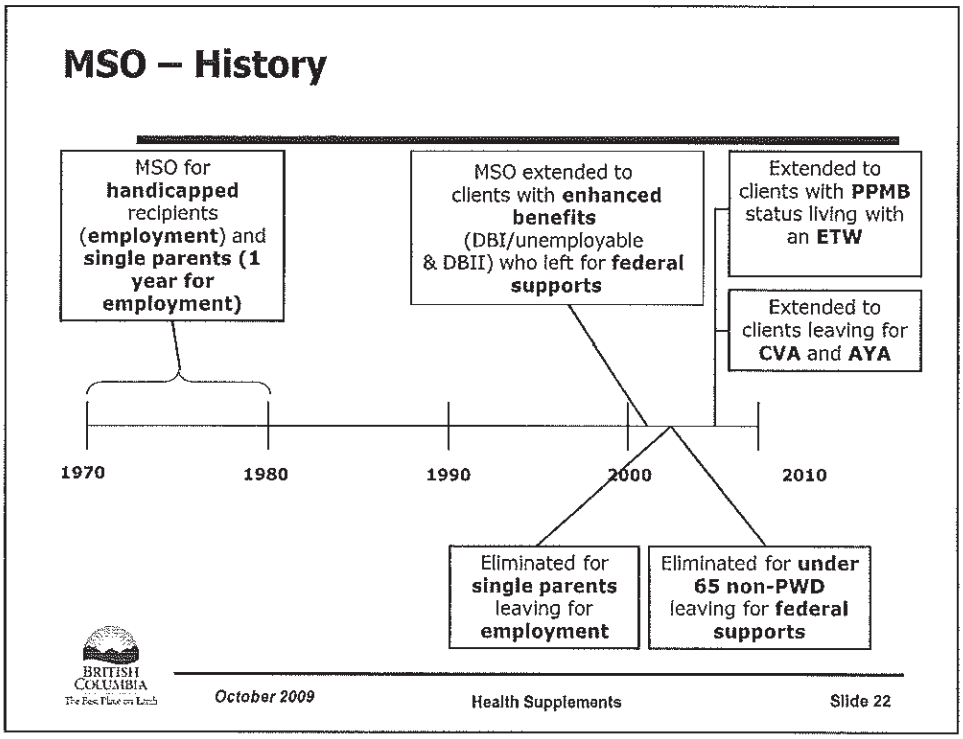
•By regulation MHSD provides product supplements only

•By practice: Staff directive 'not discontinue the MNS for any client who exits disability assistance because they turn 65 or because they become eligible for CPP Benefits

•By practice: Medical transportation

Cash supplements:

MNS, Diet allowance, Medical transportation, Natal allowance



•Both Alberta and Ontario MSO – type programs are income-tested. Alberta conducts annual review, Ontario is time limited.

•Graph indicates that there has been no consistent approach to MSO

2001

•Under BCB recipients and their dependents who left for work retained MSO with no time limit.

•Single parents who left for employment retained their benefits for one year as a transitional benefit.

•Major shift - MSO now includes recipients eligible for enhanced benefits who become ineligible for federal supports.

2002

•Eliminated for under 65 non-PWD leaving for federal supports

•People under 65 without PWD designation who were receiving MSO at the time of this change were grand parented.

•Dependent children continued to have their basic dental and optical needs met through the Healthy Kids program after their parents left assistance.

2005

MSO eligibility extended to persons eligible for general health supplements, or their spouse, who leave income or disability assistance due to receiving a lump sum payment as part of the CPP mediated class action settlement.

2008

MSO was also being extended to:

•families leaving assistance for the Crime Victim Assistance (CVA) program; and

•persons with the PWD designation, or their spouse, who leave disability assistance for financial assistance through the MCFD Agreements with Young Adults (AYA). AYA provides supports to 19 to 24 year-olds who were under a Continuing Custody Order or were in a Youth Agreement at age 19.

MSO – Budget & Expenditures

- Approximately 21,000 (08) files (MSO + LTHN)
- Tracking expenditures by these client types is challenging because:
  - LTHN and MSO share the same file type (08) in MIS
  - Expenditures for LTHN and MSO clients are recorded in MIS, PBC and the CAT system with HAB
  - Largest expenditures from MSO are from dental
- There is no distinct budget specific to MSO or LTHN; budgets are tied to individual supplements
- Lack of information, tracking and reporting justifies need for proposed changes

BRITISH COLUMBIA
The Best Place on Earth

October 2009 Health Supplements Slide 23

Assumption:

As with MNS, medical supplies and equipment – a growing caseload means increased costs.

MSO – Issues

- Intent of MSO: **transitional** versus permanent
- **Inequity** between MSO seniors and non-MSO seniors
- **Discrepancies** between Regulation, policy and practice
- **Combined** tracking for MSO and LTHN
- Providing **MNS** to PWDs exiting assistance for federal benefits

s.13

Consultations:

HAB, HRB, PLMS, Legal and field

MSO – Options

s.13

Options – s.13

s.13

Options – s.13

s.13

Options - s.13

s.13

s.13

Options – MSO Recommendation Summary

Regulation

s.13

- Provide MSO for PWD clients who leave for employment, CVA and the tube feed supplement for clients in receipt of tube feeds at time of transition to MSO (with annual income test based on MSP Premium Assistance rates)
- Limit available supplements under MSO to: medical equipment and supplies, dental, extended medical therapies, optical, tube feed (if in receipt at the time of transition) medical transportation and MNS (for PWDs who leave for federal supports)

Procedures

- s.13

Estimated systems costs: $0 – med trans
Cost savings: Yes

BRITISH COLUMBIA
The Best Place on Earth

October 2009 Health Supplements Slide 29

Regulatory changes:

•MSO to PWD clients who leave assistance for employment **(as long as they continue to live in BC).**

•Cash supplements under MSO = MNS and medical transportation

•Limit eligible items under LTHN as **medical supplies, medical equipment and devices and medical transportation** in regulation

•Implement income tested cost-sharing for LTHN based on **MSP Premium Assistance thresholds**

Life Threatening Health Need – Current Policy

Life Threatening Health Need (LTHN) is intended to provide a specific health supplement for any resident of BC (including BCEA clients not otherwise eligible for schedule C, e.g. ETWs), who faces an **imminent** threat to their life and has no other resources to meet that need.

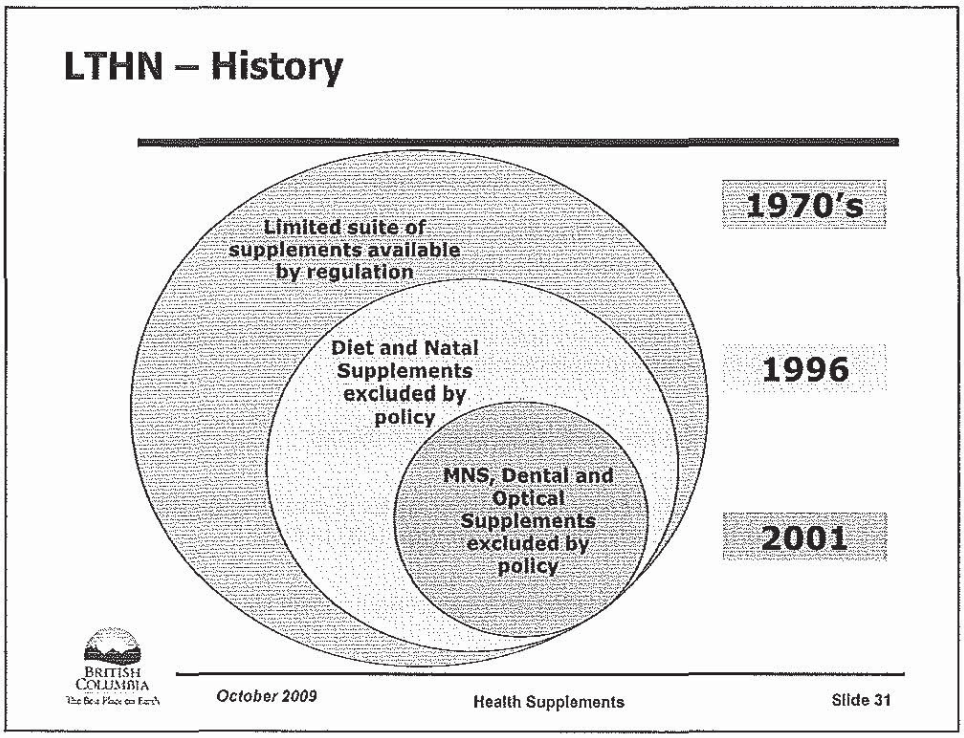
Regulation:	Eligible for any schedule C supplement (medical equipment & supplies, dental, optical, extended medical therapies, medical transportation, infant, natal)
Policy:	Non eligible items include diet, natal, MNS, nutritional and optical

BRITISH COLUMBIA

October 2009 **Health Supplements** **Slide 30**

•**Alberta and Ontario** have a universal health supplement program outside the welfare ministry

•Non-clients can access assistance to meet a one time emergency need based on a **financial assessment** and **income thresholds**



1970s supplements limited to:

Hospital insurance benefits, MSP, rx. drugs through Pharmacare, non-drugs (surgical supplies, appliances, wheelchairs, walkers, crutches), hearing aids, dental, dentures, eyewear, transportation, emergency drugs, and exams for employability. Diet and natal allowances were available under schedule A.

LTHN policy currently excludes:

- Diet supplements
- Natal supplements
- Monthly nutritional supplement (MNS)
- Short-term nutritional supplement
- Optical services

LTHN – Budget & Expenditures

- Expenditures for LTHN and MSO clients are recorded in MIS, PBC and the CAT system with HAB
- There is no distinct budget specific to MSO or LTHN; budgets are tied to individual supplements
- Largest expenditures from MSO are from dental
- Tracking expenditures by these client types is challenging as LTHN and MSO share the same file type (08) in MIS
- Lack of information, tracking and reporting justifies need for proposed changes

•As with MNS, medical supplies and equipment – a growing caseload means increased costs.

LTHN – Issues

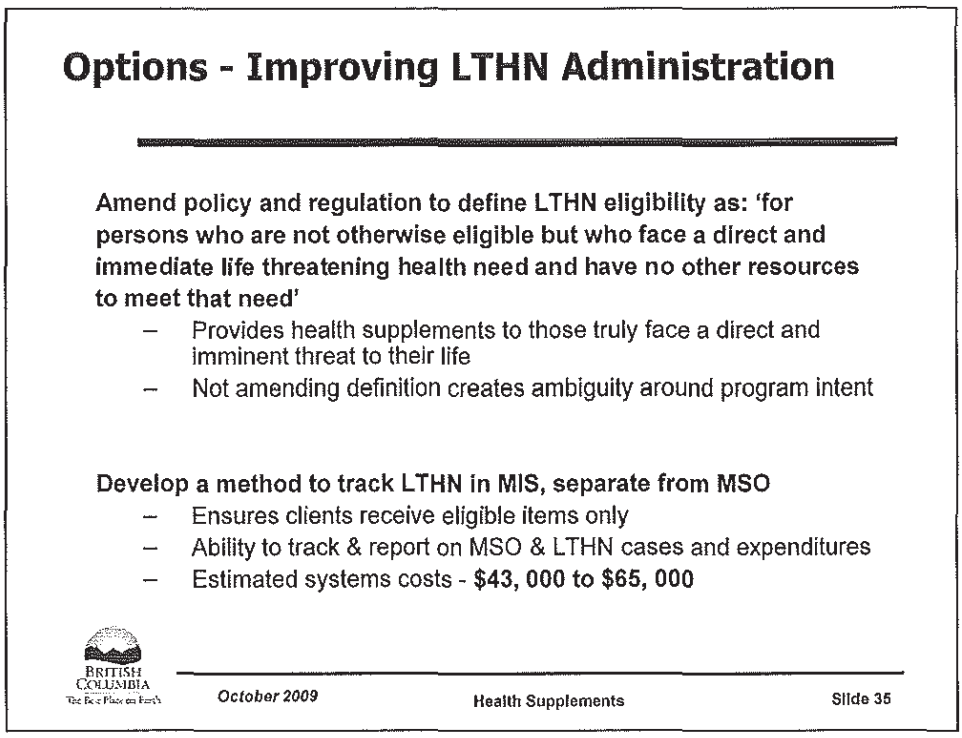
- Combined tracking for MSO and LTHN
  - LTHN files remain open
  - MSP Premium Assistance and Pharmacare are triggered for LTHN cases
- Regulation and policy are not aligned
- Clients demonstrating an indirect threat to their life are accessing supplements through LTHN
- LTHN is not thoroughly income tested

LTHN Summary

Providing a clear definition, income testing and limiting available supplements to what is required to address a truly life threatening health need will allow the LTHN program to meet its intended purpose, improve program administration and result in cost savings for MHSD and MoHS.

Options

s.13



LTHN currently defined as:

Health supplements for persons who are not otherwise eligible but who face a life-threatening health need and have no other resources to meet that need.

Regs: Any schedule C supplement (med equipment & supplies, dental, optical, extended med therapies, med trans, infant, natal)

Policy: NO diet, natal, MNS, nutritional & optical

= we are currently fettering discretion

Systems change:

•cost savings - fewer files receiving ineligible items such as dental/optical, savings for MSP and Pharmacare. Estimate for change is between **$43,200 and $64,800**.

•Cost savings for MoHS's MSP and Pharmacare programs, LTHN clients will no longer receive MSP and non-deductible Pharmacare in error.

•Status Quo – no ability to report out on LTHN and MSO separately, no cost

Options – LTHN Eligible Supplements

s.13

Amend regulation to limit eligible items under LTHN to medical supplies, medical equipment and medical transportation:

- Limiting LTHN items provides only necessary health supplements to those who demonstrate a direct and imminent threat to their life
- Regulatory amendment resolves discrepancy between regulations and policy

Options – Income Testing and Transfer

Income Testing based on MSP Premium Assistance

- Aligns thresholds with existing government programs (Healthy Kids, LTHN and MSP Premium Assistance – which is already in place and is based on tax information)
- Creates a more equitable program based on financial need
- Creating a cut-off point for eligibility could create a gap in service

s.13

BRITISH COLUMBIA

October 2009 Health Supplements Slide 37

•Current income assessment is done using the 435 Health Needs Request Form which is filled in by the applicant

s.13

Income Testing would:

•Aligns eligibility for 3 government programs (Healthy Kids, LTHN and MSP Premium Assistance – which is already in place and is based on tax information)

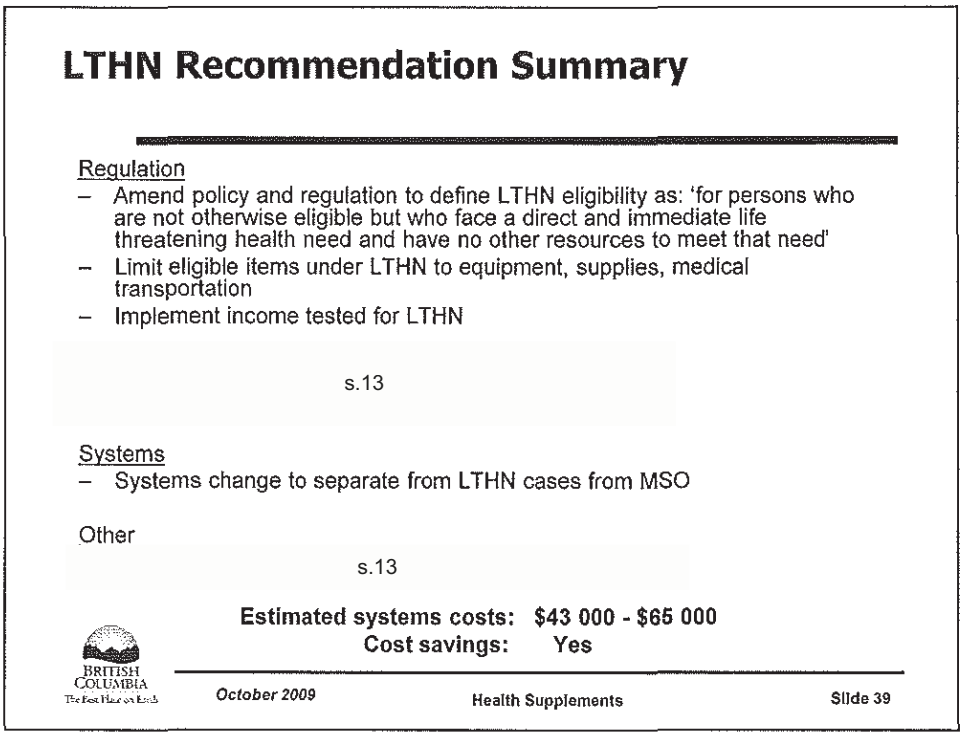
s.13

•Creating a cut-off point for eligibility could create a gap in service for those who are over the threshold by a nominal amount;

s.13

Options - s.13

s.13



Regulatory changes:

•MSO to PWD clients who leave assistance for employment **(as long as they continue to live in BC).**

•Limit eligible items under LTHN as **medical supplies, medical equipment and devices and medical transportation** in regulation

•Implement income testing for LTHN based on **MSP Premium Assistance thresholds**

Next Steps: PON, DN, and implementation (which would include amending the Health Needs Request form)

Pages 40 through 63 redacted for the following reasons:
- -
Not responsive

Supplements - Next Steps

- Establish implementation date(s)
- Finalize policy decisions (EIAB lead)
- Development of implementation plans (RSD lead)
- Development of fee guides/catalogues (EIAB lead)
  - consultation with SMEs (HAB)
- Approval required to:
  - commence systems development ($)
  - initiate discussions with FOI (PIAs)
  - initiate discussions with other stakeholders

BRITISH COLUMBIA

October 2009 Supplements Review Slide 64

Discussion/Communication with stakeholders:

•MNS and diet

•Consultation with HAB staff re: criteria for wasting symptoms

•Communication with BCMA and nurse practitioner's association

Orthotics and Bracing

•Consultation with HAB staff re: schedule/catalogue

•Communication with health professionals

Medical Equipment/Medical Supplies

•Consultation with HAB staff re: schedule/guide

•Communication with health professionals (OT, physicians, nurse pracs)

Not Responsive

Dental:

•Provincial Services (assistance from Internal Communications)

- •Cost of production of fee schedules (Queen's printer)

•Pacific Blue Cross

- •Programming requirements to support changes to fees, fee schedule and rules
- •Cost of delivery of fee schedules

•Communications with Dentist, Denturist and Hygienist Associations

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

DATE: October 5, 2009

PREPARED FOR: Cairine MacDonald, Deputy Minister

ISSUE: Changes to the dental program

BACKGROUND:

The Ministry of Housing and Social Development (MHSD) provides basic dental services, such as restorations, extractions, and preventative services to recipients of disability and income assistance who are eligible for general health supplements as well as their dependent children and children from low income families who are eligible through the BC Healthy Kids Program. Emergency dental services for the relief of pain are provided to all recipients of income assistance, disability assistance, hardship assistance and Healthy Kids. Dentures, orthodontic, and crown and bridge services are provided to recipients who meet specific eligibility criteria.

MHSD's caseload is growing and so are dental expenditures – projected to be $50 million in 2009/10. In light of these cost pressures, MHSD conducted a comprehensive review of the dental program (see Appendix B – Dental Policy Options Note). The review considered options for reducing costs, addressing deficiencies in the dental program and ensuring that funds are most beneficially targeted. Key issues for consideration have been identified.

DISCUSSION:

Healthy Kids

- In 1996, MHSD introduced the Healthy Kids program which provided $500 in dental coverage for children 0 to 12 years of age. In 1997, the program was expanded to the current $700 limit for children up to age 18. Previous to May 2001, those families receiving partial Medical Services Plan (MSP) premium assistance received 50 percent basic coverage. Healthy Kids removes a welfare wall as coverage is very similar for children of families on income assistance.
- Currently, families who have an adjusted net income of $28,000 or less qualify for MSP premium coverage and are also eligible for Healthy Kids dental coverage. Many families eligible for Healthy Kids coverage also have private coverage – one of the reasons this group has low uptake of MHSD's plan.
- Dental and other health professionals indicate that dental care is crucial throughout early childhood development and throughout dentition development. Most children have not completed dentition development until late adolescence.

s.13

Checkups

- MHSD clients are currently able to receive two checkups per year including associated services such as polishing, exams and x-rays. Annual or 9-month checkups are the norm for most private dental plans. MHSD clients are limited to a full set of x-rays every 3 years. Options could be explored for further limiting x-rays use.

Denture rates

- MHSD denture fees are very low and sometimes do not cover the lab cost of manufacturing the denture, leaving the dentists out of pocket. Dentists would prefer that lab fees are paid separately. PBC and MHSD include the lab fee within the fee amount as a cost control mechanism.
- Denturists often manufacture their own dentures while dentists must utilize a lab. The rates denturists charge the general public are less than rates charged by dentists. Likewise, MHSD rates are less for denturists than dentists.

Children's limit

- The current children's limit for basic dental is $700 per year. When children require treatment beyond the $700 limit, dentists are often able to provide this by jumping through administrative hoops and billing through emergency, General Anesthetic (GA) coverage, or securing exceptions.
- Some children require a large amount of dental treatment over a short period of time to deal with accumulated problems. After the initial dental work is completed, treatment need usually drops and remains low. Ideally, subsequent dental treatment is limited to preventative services. Alternatively, a dentist must provide several short term fixes over time within the current $700 limit.
- If MHSD were to change the children's dental limit from $700 per year to $1400 per two-years, consistent with the two-year limit for adults, dentists could plan and provide treatment more efficiently and effectively while improving children's long term dental health.

Dental under General Anaesthetic (GA)

- Currently, clients designated as Persons with Disabilities (PWD) and children are eligible for an additional $500 in dental treatment performed under GA. This amount is often insufficient to complete all the required dental work -- especially for PWD with severe conditions.
- Repeat GA visits can compromise a client's health and result in significant costs to the health care system – especially if the GA is performed in a hospital.
- The Children's and Women's Health Centre (CWHC) administers a MHS program that provides funding to pay for GA facility fees for children up to age 10 and PWD. There is currently a gap in CWHC GA funding coverage - children with disabilities over the age of 10 are not yet MHSD clients and are thus ineligible.

s.13

Not Responsive

OPTIONS:

s.13

Option 3 (Recommended):
A) As outlined in Appendix A, immediately proceed with optimizing the dental program for sustainability while balancing the needs of dental professionals and clients.
Implications:

- The dental program will be restructured to ensure sustainability, while addressing critical deficiencies and making important improvements.

Not Responsive

s.13

Attachments:
Appendix A – Recommended Policy Changes
Appendix B – Dental Policy Options Note

Approved/Not Approved Date:
Original signed by CM on Nov 17, 2009
Cairine MacDonald
Deputy Minister

PREPARED BY:	REVIEWED BY (please initial):	DATE:
Erik Bekker Policy and Research Analyst Strategic Policy and Research Branch (250) 387-7005	Alison Bath, Director Employment and Income Assistance Branch	Orig signed by DJ for AB on Nov 6/09
	Rob Bruce, Executive Director Employment and Income Assistance Branch	Original signed by RB on Nov 12/09
	Sharon Moysey, ADM Management Services	Original signed by SM on Oct 1/09
	Heather Davidson, ADM Regional Services Division	Original signed by HD on Oct 23/09
	Molly Harrington, ADM Policy and Research Division	Original signed by MH on Nov 16/09

Cliff # 154852
Appendix A – Recommended Policy Changes

Not Responsive

Annual check-up

- Limit all examinations in any combination to once per calendar year.
- Approximately 30,000 MHSD clients impacted, of which 22,000 are children.

Not Responsive

- Limit non-emergency x-rays to $54.71 every 2 years (currently $54.71 every year). Limit Panoramic Film x-rays once every 3 years (currently once every 2 years). Not Responsive
- These and other options for adjusting the MHSD dental schedule need to be fully explored with the BCDA

Not Responsive

Denture rates

- Increase denture fees for dentists and denturists to 75% of the fees in their respective PBC fee guides.
- The BCDA and denturists will be pleased with these changes (although still not receiving as much as they might like).

Not Responsive

Change children's limit to $1400 every 2 years

- To take effect retroactively January 1, 2009.
- Cost neutral over time although expenditures are likely to increase slightly the first year.
- Emergency dental will still be available to address emergency dental needs.

Not Responsive

Increase dental limit under GA to $1000

- At a cost of $175,000 if 700 children use, on average, an additional $250 in dental over and above the existing limit (In 2008, 658 children used the entire combined $1200 limit).
- The extra dental under GA will make treatment more efficient for all parties involved and will be more administratively straightforward for dentists, MHSD and PBC.
- Reduces the need for repeat appointments under GA.
- Addresses the request from the BCDA for higher GA limits.

Not Responsive

Not Responsive

Cliff #154852

APPENDIX B – Policy Options Note

DATE: August 20, 2009

PREPARED FOR: Rob Bruce, Executive Director, Strategic Policy and Research Branch

ISSUE: Dental Program Review

BACKGROUND: The Ministry of Housing and Social Development (MHSD) provides basic dental services, such as restorations, extractions, and preventative services to recipients of disability assistance and income assistance who are eligible for general health supplements as well as their dependent children and children from low income families who are eligible through the BC Healthy Kids Program. Emergency dental services for the relief of pain are provided to all recipients of income assistance, disability assistance, hardship assistance and Healthy Kids. Dentures, orthodontic, and crown and bridge services are provided to recipients who meet specific eligibility criteria. See Appendix A for:

- A history of the dental program.
- An overview of current MHSD dental coverage.

MHSD's dental program is based on a fee for service model. Dentists are reimbursed for the treatment they provide by billing MHSD's dental plan through Pacific Blue Cross (PBC). Despite periodic increases, MHSD's Schedule of Fee Allowances has not kept pace with the BCDA set fee guide. Currently, MHSD's fees are 67-69 percent of the BCDA's February 2009 guide. MHSD spent approximately $47M on the dental program in 2008/09.

Since 2006, the ministry has provided over $1.2M in grants to support low cost dental clinics in communities such as Prince George, Salmon Arm, Vernon, Kamloops and the Downtown Eastside. Of the $1.2M, $300,000 was provided to the Dawson Creek dental clinic, a clinic made possible by a partnership with MHSD, the BC Dental Association (BCDA) and the Northern Health Authority. The grants were used for equipment and capital costs. Low cost clinics are further supported by fee for service billing through patients with dental coverage – including MHSD dental program coverage.

Many supports that the ministry provides, especially health-related supports, have increased significantly over the last few years. The Dental Program is an important health program for clients, but is an increasingly expensive program. With the caseload expected to grow over the next few years, program effectiveness needs to be examined. The purpose of this note is to provide an overview of the program, identify issues and trends, and recommend policy options for providing dental coverage, with a view to balancing the needs of dentists, clients and MHSD.

DISCUSSION:

Program Comparison

While comparing dental plans with different structures can be difficult, overall, MHSD generally provides a dental plan that is comparable to other provinces. MHSD's dental program is clearly inferior to the dental plans offered by MCFD, Health Canada and Washington State. (See Appendix B for additional details of the following comparisons.)

Jurisdictional:

Alberta:

- All dental coverage is provided through Alberta Employment and Immigration.
- Expected to work and learner households qualify for basic services such as extractions and fillings to alleviate pain and infection. For children in these households, some additional services such as cleaning and exams are covered.
- Not expected to work households and assured income for the severely handicapped (AISH) clients qualify for additional services that address longer term needs – such as exams. In the 1990's, Alberta paid 75% of full dental fees for most clients and 100% of full fees for "handicapped children".
- All clients, including expected to work, who leave income assistance remain eligible for the dental benefits they were in receipt of, subject to income limits. Eligibility is reviewed each September, to ensure clients are still below the qualifying income threshold.
- All low income seniors are eligible for dental care including dentures and children are eligible for basic dental benefits including fillings and preventative services. The dental limit for seniors is $5,000 every 5 years.

Ontario:

- Ontario Works clients may be eligible for emergency dental that supports the person's employability or participation requirements during and after receiving assistance (Ministry of Community and Social Services).
- The Ministry of Community and Social Services also provides basic dental coverage for clients of the Ontario Disability Support Program. Additional dental services may be provided if the client's disability, prescribed medications or prescribed treatment affects their oral health
- Children of financially tested families are covered for dental conditions that require urgent care through Ontario's Ministry of Health.
- Some Ontario municipalities provide subsidized dental care for seniors.
- When comparing the BC and Ontario fee guides, on average, BC pays 7.65% more than what Ontario pays their GPs but 10.3% less than what Ontario pays their specialists. BC pays quite a bit less than Ontario for diagnostic and preventative procedures.

Health Canada's dental coverage for Status First Nations and Inuit:

- The dental component of Health Canada's Non-Insured Health Benefits Program covers dental services including: diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery, orthodontic and adjunctive services - most dental procedures that treat disease or the consequences of dental disease.
- Funding of dental services is determined on an individual basis taking into consideration criteria such as the client's oral health status and past client history.
- Certain services may need predetermination/prior approval.
- There are no annual limits for treatment – only prescribed frequencies.
- Reimbursement rates are sometimes the same and sometimes less than those outlined in provincial dental association fee guides.

Washington State

- Provides dental services according to a dental fee schedule subject to restrictions and limitations (but not limits)/
- Provides basic dental for:
    - Low-income residents who meet certain eligibility requirements.
    - Alcohol and Drug Abuse Treatment patients.
    - Employable clients on assistance.
- Provides additional dental services including crowns and dentures for:
    - Categorically Needy (categorical and income tested).
    - Medically Needy (categorical and income tested).
    - State Children's Health Insurance Program (income tested).

Province of BC

BC Public Service and MHSD dental plans

- Dental advocates have asked how MHSD's dental plan compares to the dental plan available to the BC Public Service (BCPS).
- When comparing the two plans, coverage for basic dental care is effectively similar. Crown and bridge work, orthodontic and denture services are partially covered for everyone under the BCPS plan, while MHSD clients can access these services for free in special circumstances.
- Depending on client circumstances, a client could be better off under the MHSD plan.

Medical Services Plan (MSP) Ministry of Health Services

- Provision of basic dental care is not included in the health care system and is excluded from the Canada Health Act and the Medicare Protection Act.
- The provincial government has a contract with the BCDA which agrees to a fee schedule for limited dental and oral surgery covered by MSP when medically required to be performed in hospital.
- When comparing common procedures between the MSP fee guide, the BCDA fee guide and the MHSD fee guide (See Appendix B for more details), on average:
    - The MSP fee guide is 88% of the MHSD fee guide
    - The MHSD fee guide is 67% of the BCDA fee guide
    - The MSP fee guide is 59% of the BCDA fee guide
- In addition to the fees paid by MSP, there are surcharges applicable in specific situations such as the $199 call out charge for general dentists performing oral surgery. It should also be noted that in hospital, dentists are not incurring the same overhead costs as in a private practice.
- Surgical removal of an impacted third molar (wisdom tooth) is an MSP insured service only when hospitalization is medically required, due to the extreme complexity of the extraction and where there is associated pathology. The removal of healthy wisdom teeth, even if impacted, is not a benefit.
- The contract with the BCDA also acknowledges the funding provided by the province to cover programs that provide orthodontic services related to severe congenital facial abnormalities. In order to qualify for these programs, patients must meet certain criteria and funds must be available. The client's dentist must submit a detailed treatment plan for evaluation and approval by an expert screening committee made up of volunteer dentists with expertise. The programs are as follows:
    - Cleft Lip and Palate Program. Limited to those who are 25 years or younger. Funded by $200,000 over three years.

- Ectodermal-Ectodactyly-Clefting and Ectodermal Dysplasia Syndrome Program. Limited to those who are 20 years or younger. Funded by $100,000 per year.
- Prosthetic Management of Severe Dentofacial Anomalies Program. Funded by $200,000 over three years.

Ministry of Children and Family Development (MCFD) - Children in care

- MCFD has a dental program for children in care. Before 2001, children in care were eligible for dental through MHSD according to the benefit structure (fees and services) for income assistance children. In 2001, responsibility and administration was transferred to MCFD and dentists could then bill according to PBC's fee schedule at 100% of BCDA fee guide rates in order to improve accessibility. Currently, the program serves 8,900 children at a cost of $2.5M each year. MCFD signed a $10M / 5 year contract with PBC.

Plan Design

How is a dental plan determined (fees and services)?

1. BCDA sets their fee schedule. On average, the BCDA increases fees within their guide by 3% each year. This differs from doctors and nurses who negotiate compensation with the province, including changes to MSP fees for doctors. It should be noted that average wage increases negotiated by BC nurses and doctors are comparable to average increases to the BCDA fee guide.
2. For the most part, PBC adopts the fees set by the BCDA and adopts most of the procedures. PBC looks for new codes and sets frequencies.
3. The insurance plan holder determines what services and frequencies they would like in their plan. The plan holder also determines what percentage of dental procedures in categories A, B and C should be paid by the plan. Category A is basic dental. Category B is crown, bridge and dentures. Category C is orthodontics. In MHSD's case, we pay 100% of all services within and according to our fee guide.
4. The cost to the insurance plan holder is the total payments to dentists plus an administration fee of 8%-15%. For MHSD our administration fee is approximately 3.9%.

How is the BC Public Service dental plan determined?

- The BC Public Service dental plan is negotiated through the collective bargaining process. The excluded employees plan was designed by an employee focus group and approved by an executive steering committee.
- The BC Public Service Agency (PSA) is responsible for contract management and maintaining the relationship with PBC for public service employees.
- The contract with PBC was put out to RFP in 2007. PBC's winning bid included rates for 5 years and an option to renew for another 5 years. At renewal, the PSA will negotiate rates if the contract is to be extended. Typically, larger benefit contracts should be for a longer term such as 10 years considering the impact to clients and the cost to change providers.
- The dental administration fee is just under 3% and is adjusted annually based on the consumer price index.
- The contract with PBC states that the plan will be based on the PBC dental fee schedule. Any changes to the dental plan must go through collective bargaining.

Trend Analysis

Despite the coverage provided by MHSD, dental usage for eligible MHSD clients is approximately 37%. Low income Canadians typically have low dental usage - MHSD clients are no exception and in fact have additional barriers. British Columbians who do not regularly seek dental care do not seem to be influenced by dental coverage when determining how often they visit the dentist. While 80% of dentists bill MHSD's dental plan in a given year, 30% of dentists do not accept MHSD clients or accept only a quota of clients. 30% of dentists accepting MHSD clients balance bill the difference between MHSD's fee schedule and the BCDA fee guide. Awareness of dental coverage plays a roll - it is estimated by dentists that as many as 50% of MHSD and Healthy Kids clients are unaware of their dental coverage.

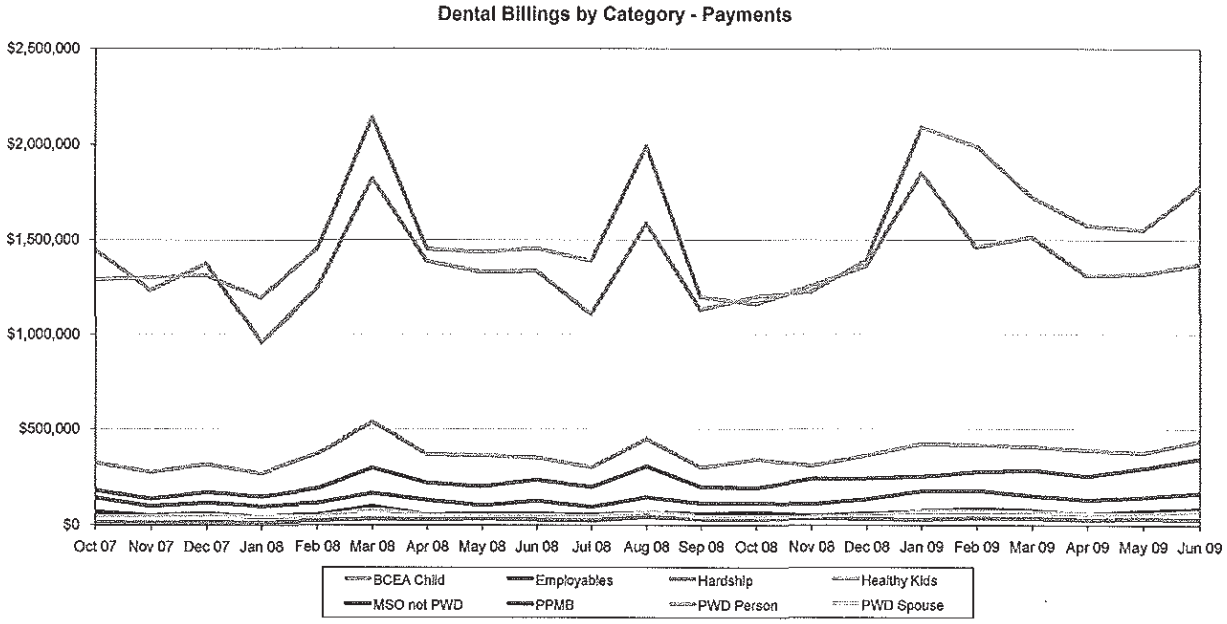
Dental budget and Erik's projected expenditures:

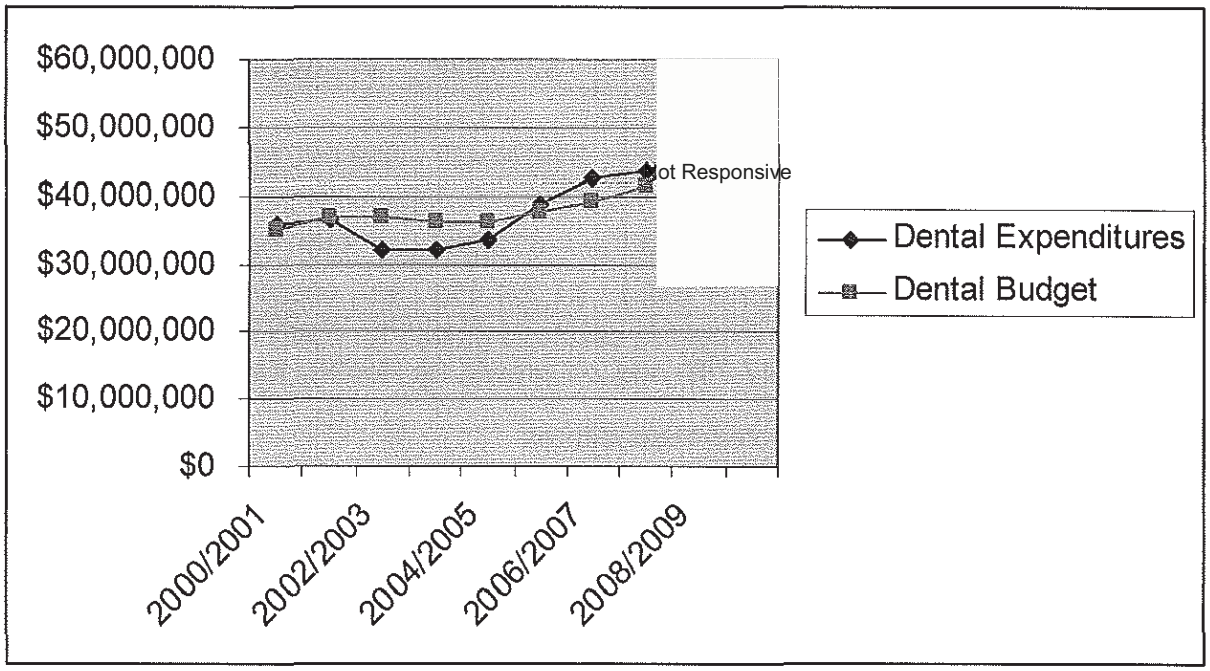
	2008/2009 Budget	Expenditures	2008/2009 Budget Room
Dental Services - Non PWD	$9,200,000	$9,496,749	($296,749)
Dental Services - PWD	$20,000,000	$19,724,322	$275,678
Healthy Kids - Dental	$19,000,000	$17,325,523	$1,674,477
Orthodontia - Children	$300,000	$226,233	$73,767
Total	$48,500,000	$46,772,828	$1,727,172

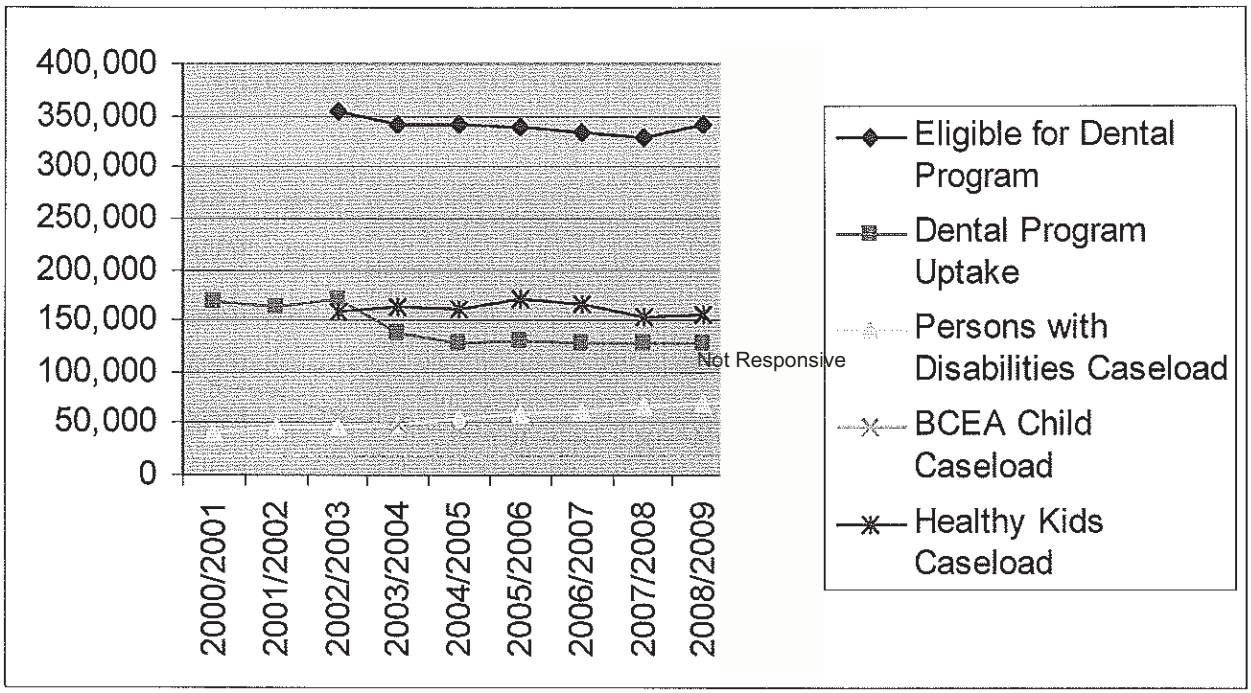
Not Responsive

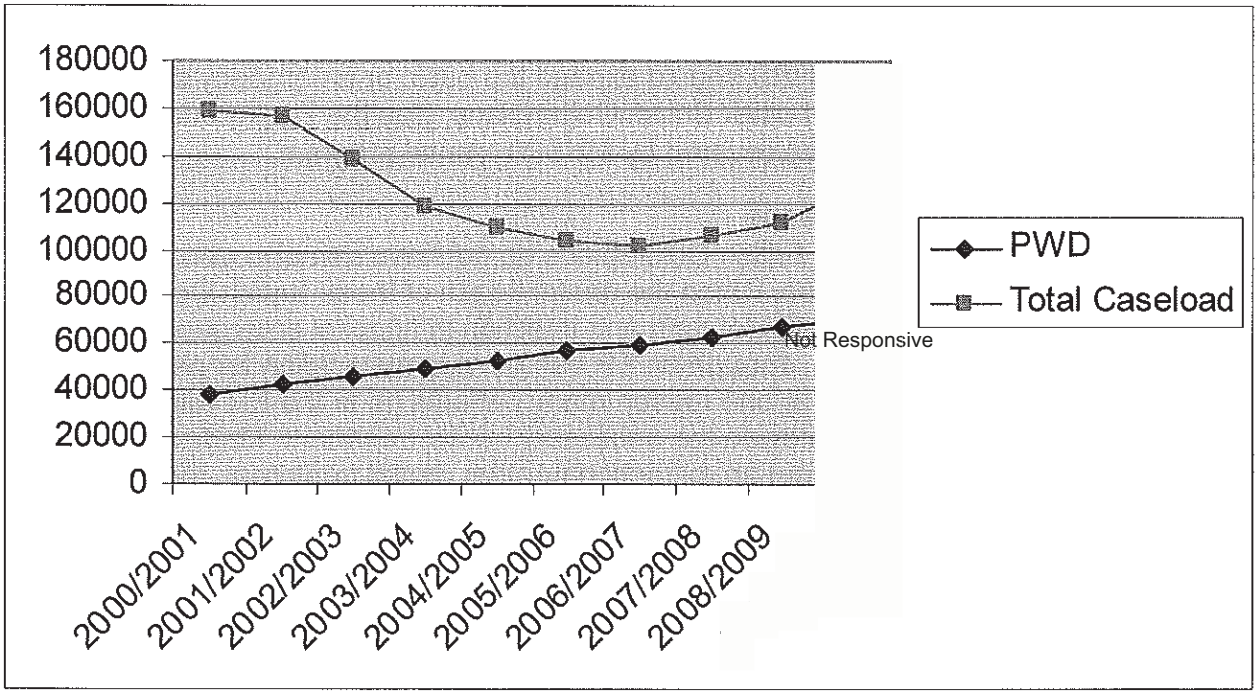
Forecast expenditures based on expected caseload growth for PWD (6.2%), overall caseload growth for Non-PWD (17.7%) and 2% growth for Healthy Kids and Orthodontia.

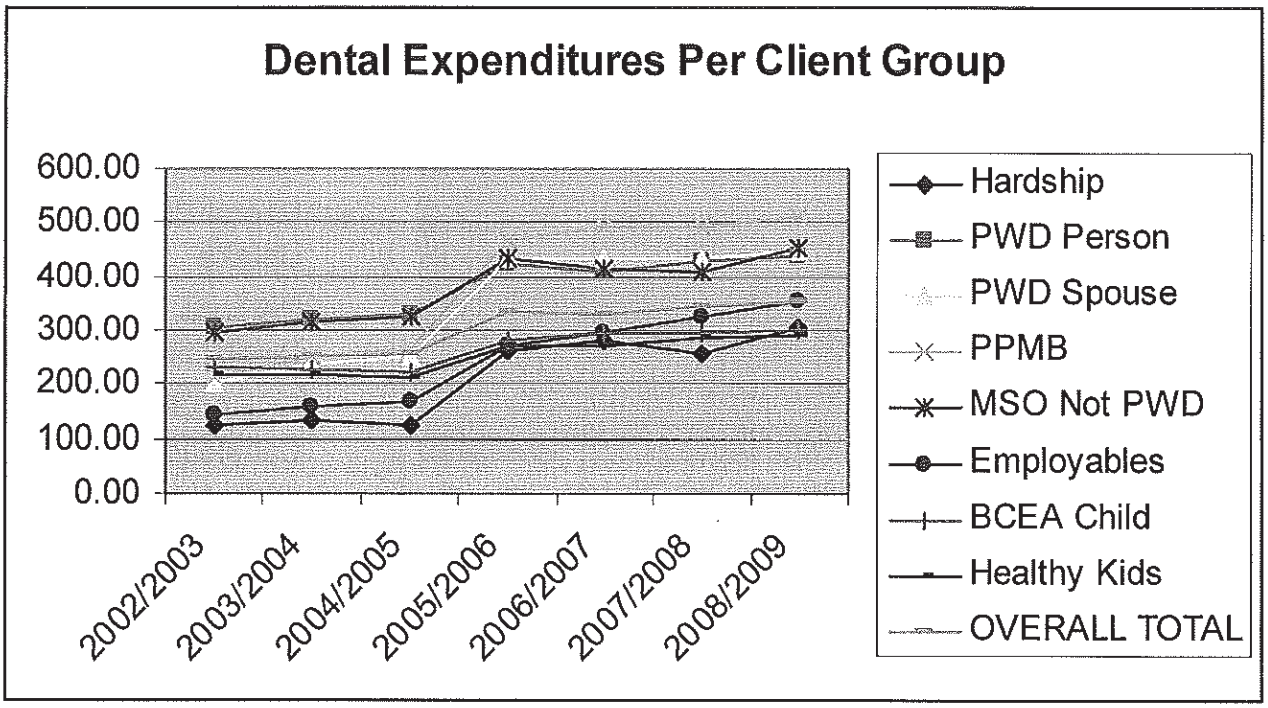
Not Responsive


Dental Billings by Category - Payments
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Oct 07 Nov 07 Dec 07 Jan 08 Feb 08 Mar 08 Apr 08 May 08 Jun 08 Jul 08 Aug 08 Sep 08 Oct 08 Nov 08 Dec 08 Jan 09 Feb 09 Mar 09 Apr 09 May 09 Jun 09
BCEA Child
Employables
Hardship
Healthy Kids
MSO not PWD
PPMB
PWD Person
PWD Spouse


$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$0
2000/2001
2002/2003
2004/2005
2006/2007
2008/2009
Dental Expenditures
Dental Budget


400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
2000/2001
2001/2002
2002/2003
2003/2004
2004/2005
2005/2006
2006/2007
2007/2008
2008/2009
Eligible for Dental Program
Dental Program Uptake
Persons with Disabilities Caseload
BCEA Child Caseload
Healthy Kids Caseload
Not Responsive


180000
160000
140000
120000
100000
80000
60000
40000
20000
0
2000/2001
2001/2002
2002/2003
2003/2004
2004/2005
2005/2006
2006/2007
2007/2008
2008/2009
PWD
Total Caseload
Not Responsive



Client Eligibility

This section will consider if MHSD should expand the basic or emergency dental coverage available to MHSD clients and other British Columbians. See the Background and Appendix A for details of what is currently covered by MHSD's dental program.

Low income British Columbians

- Many low income working British Columbians do not have dental coverage - through their employers or otherwise. When the dental health of these British Columbians deteriorates, some seek relief for pain and infection in hospital emergency rooms (ER), as do some MHSD clients. Though an ER can provide medication for pain and infection (obtaining free medication is one reason many patients go to the ER with dental pain), they are not equipped to provide the necessary dental treatment. Medications will not treat the problem and without an extraction or other dental treatment, the patient may return to the ER for further pain relief. If left untreated, the condition may become chronic and can impact the overall health of the patient.
- The BCDA estimates that it costs approximately $200 for a patient to be processed through the ER, before they are even seen. In the case of MHSD clients, they can be treated in a dental office for less and have a permanent resolution to their pain.

s.13

- MHSD stopped using the Dental Emergency form in 2002 when the Emergency Dental Fee Schedule was introduced.
- With the emergency fee schedule, the preapproval process to extend services beyond the limits on the emergency form was eliminated, and dentists had to bill in accordance with the emergency schedule through PBC.

s.13

Dental coverage for low income seniors and long-term care facility residents

- The Premier's Council on Aging and Seniors' Issues recommended government-supported dental coverage for low income seniors.
- With an aging population, the number of eligible individuals will rapidly increase over the next 15 years.
- Today's seniors are retaining their teeth longer due to better preventive oral healthcare. Because they are keeping their teeth, seniors are visiting their dentists more often.
- Diagnosis and treatment for geriatric patients is different than what is required for younger patients due to changes in teeth and other oral tissues that occur with age. It is especially challenging given the extensive oral disease and medical problems associated with the elderly.
- The Dental Care Plan of BC (see Appendix A for details of how the plan fit into the history of MHSD's dental program), which existed in the early 1980s and covered clients, children, seniors and low income British Columbians, was 'suspended' after just 18 months due to the prohibitive cost.
- Provision of dental services for seniors in other provinces is limited to the following:
    - Alberta provides basic dental services for low-to-moderate-income seniors receiving financial assistance.
    - Ontario does not provide dental services for seniors although some municipalities subsidize dental care for seniors.
    - PEI provides free screening for LTC residents.
    - In Quebec, every Health Insurance Card holder is entitled to certain oral surgery services in the event of a trauma or illness, along with necessary examinations, local or general anaesthesia, and x-rays.

Dental care for people with developmental disabilities (PDD)

- Dental services for PDD with severe conditions must often be provided under General Anaesthetic (GA). Limited capacity in private GA facilities and hospitals has led to long wait lists.
- The dental program at UBC treats 300-400 extremely compromised patients a year from around the province. Extremely compromised patients usually need to be treated in

hospital while less severe patients can be treated at a private GA facility (see GA section for more GA related issues involving PWD).

- MHSD's dental program coverage is generally insufficient and dentists are generally inadequately trained or equipped to meet the dental care needs for PDD with severe conditions.
- Many PDD suffer dry mouth as a side affect of taking certain medications or as a side affect of certain medical conditions. Dry mouth increases tooth decay and can make it difficult to wear dentures.

s.13

s.13

Program Structure

This section looks considers what dental services should be provided (fees and limits) and how those services should be provided.

MHSD dental rates

- Increasing the rates MHSD pays for dental procedures is one way to encourage dentists to accept clients and reduce balance billing. (Low rates aren't the only reason dentists can be reluctant to accept MHSD clients; a high no-show rate and a trend towards practices offering and patients seeking higher-end cosmetic dentistry play a roll).
- MHSD's Schedule of Fee Allowances has not kept pace with the BCDA provincial fee guide. On average, the BCDA raises the fees in their fee guide by 3% per year. Currently, MHSD's fees are 67-69 percent of the BCDA's provincial guide.
- Since dental limits have remained the same for children since the early 1980s and have decreased for adults since that time, periodic fee increases have eroded the amount of dental services that clients can access.
- Among the provinces, BC leads only Ontario when comparing how much of the province's dentist association fee guide is paid by the corresponding provincial guide:

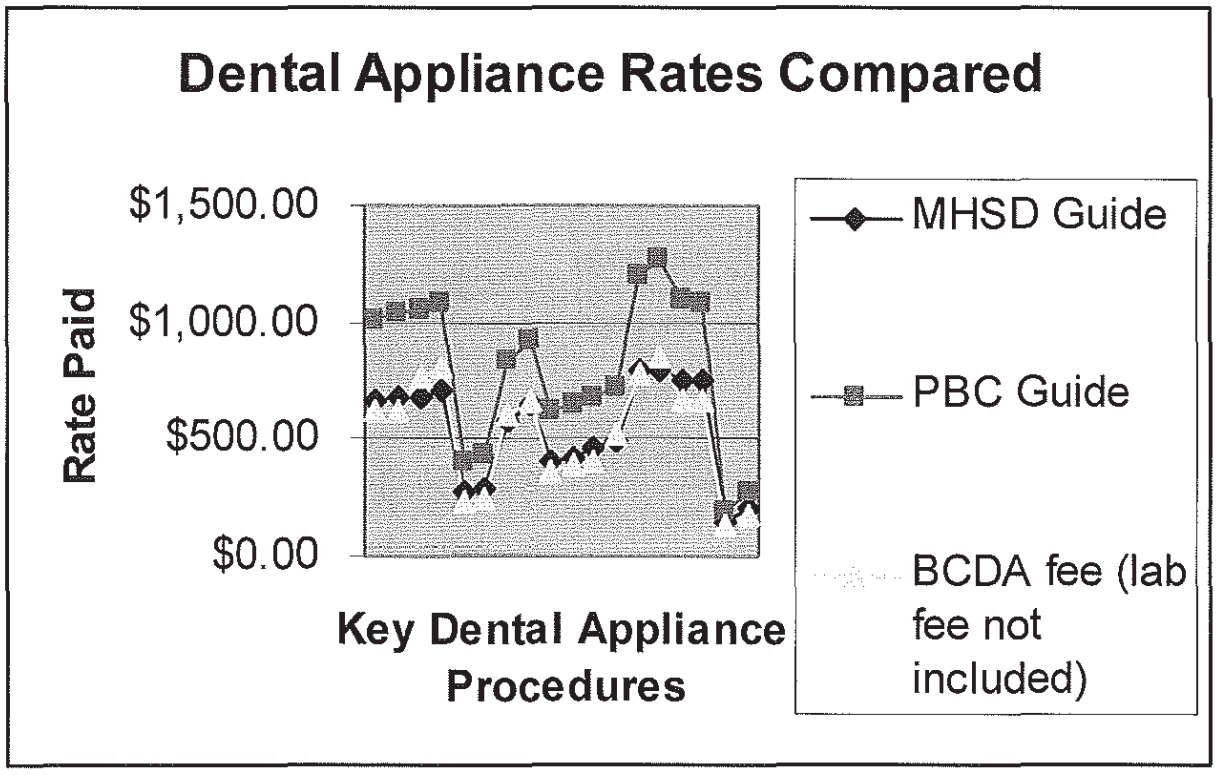
2009 provincial social services fee guide rate rankings for dental

Province	Percentage of provincial fee guide paid	Approximate rank
British Columbia	67-69% (2009)	**9**
Alberta	82% (2008)	**5**
Saskatchewan	92.82% (2007)	**3**
Manitoba	90% (2008)	**4**
Ontario	59% (2008)	**10**
Quebec	75% (2008)	**8**
Newfoundland & Labrador	95% (2006)	**2**
New Brunswick	80% (2008)	**6**
Prince Edward Island	100% (2009)	**1**
Nova Scotia	80% (2008)	**6**

Dentures and s.13

- MHSD fee schedule amounts for dentures and s.13 are low. Fees charged by labs for processing these appliances are often greater than MHSD reimbursement for the entire procedure. Lab fees for a full set of dentures range from $1000-$1600. The MHSD fee schedule amount for a full set is $1345 – inclusive of both the lab fee and the dentist's treatment service fee.
- If a client gets a complete set of dentures, they will have completely used their dental limit and will be into their emergency dental. Likewise, a client could easily be into their emergency dental if they are only getting an upper or lower denture.

- After 6 months, clients often need a reline because their gums have shrunk. Since they are likely into their emergency dental, they do not qualify for a lab processed reline and are instead eligible for only a direct reline. Direct relines often do not last. A loose denture is more likely to break or be lost. In this situation, a client would have to wait two years before they could get a lab processed permanent reline.
- Soft liners help dentures fit better. As with relines, they are not available as an emergency procedure and thus often unavailable for clients.
- If lab fees are paid separately, (up to a specified maximum in accordance with PBC's regular book of business), do not count towards a client's limit, and the dentist's professional fee amount is reduced, some room will be freed up in the client's dental limit. Administratively, paying lab fees separately is more expensive for PBC and could impact the contract.
- Alternatively, if denture and s.13 ates are increased to match PBC dental schedule rates, the lab fees are already included. This has the added benefit of simplicity, administrative savings and control of what is reimbursed for the lab fee.
- s.13



Dental limits

- MHSD clients eligible for basic dental are limited to $700 per year in dental coverage for children and $1,000 every two years for adults. If the dental limit is increased, clients would be able to obtain more dental services more efficiently – improving their short and long term dental health.
- A lower dental limit is one means of engaging clients in prioritizing needs, thus containing costs.

- As an alternative to rate increases, limits can be spread out over time to increase flexibility. For example, in 2005, limits for MHSD adults were changed from $500 per year to $1000 every two years.
- Flexibility allows for a large amount of dental treatment to be provided all at once. This can mean addressing dental problems with permanent solutions followed by prevention rather than several temporary fixes over a number of years (as can be provided by a smaller annual limit).

Reprioritize the MHSD dental fee schedule

- MHSD staff attended a BCDA workshop on August 7th, 2009. The purpose of this meeting was to consider innovative approaches and solutions for providing optimal care for children and the disabled (balancing the needs of dentists, clients and MHSD).

s.13

- Crown and Bridge work only account for $80,000 in expenditures per year.
- Outstanding billing issues:
  - Consistent coding for sedation – CDA codes often have to be changed to specific MHSD dental program codes.
  - Allow for specialist coverage for exams. When a patient is referred to a specialist, the general practitioner has often already billed for examination and diagnosis.
  - No payment until a denture is placed.
  - Policy requirement for dentists to contact the previous dentist who submitted an extraction with an incorrect tooth number. If the client is PWD with developmental disabilities, they may not be able to share who the previous dentist was or give consent for PBC to disclose this information.

s.13

Capital and infrastructural funding for community dental clinics

- In previous years, MHSD has given grants to community dental clinics for equipment and capital costs. Low cost clinics are further supported by fee for service billing through MHSD's dental program.
- In addition to increasing dental rates, both Bruce Wallace (PhD student and long time dental advocate), and the BCDA support increased funding for community clinics.
- In order to be successful and survive, community clinics need to be independently sustainable and have local champions. Community clinics are financially vulnerable.
- 40% of dental patients at community clinics are covered by MHSD's dental plan.
- If clinics can get administration support, they can generally get dentists to volunteer.
- Community dental clinics:
  - Include volunteer charitable, social enterprise, subsidized and teaching clinics.
  - Improve access to dental for all low income British Columbians.
  - Do not create a welfare wall.
  - Are often better equipped to meet client's needs than private dental practices.
  - Provide a full range of diagnostic and restorative services similar to the distribution of services in□ private practice.
  - Operate dental services to effectively accommodate both a high frequency of missed appointments and treat high numbers of emergency need patients.
  - Provide integrated care in relation to health and social services.
- The 5 largest community dental clinics in BC:
  - Annually see 23,000 patients and performed 64,000 procedures.
  - Had combined operating costs of $4 million in 2007/08.
  - Had combined operating losses of $225,000 in 2007/08.

General Anaesthetic (GA) facilities

- Currently, MHSD provides an additional $500 in dental treatment for PWD clients and children up to age 10 who meet specific eligibility criteria if the dental work they require is provided while the client is under GA in hospital or at a facility accredited by the Children's and Women's Health Centre (CWHC). The CWHC does not in fact accredit facilities but rather secures contracts at preferred rates and pays the GA fees. Highly complicated cases under GA must be performed in a hospital.

History

- In the 15 years prior to 2002, MHSD directly provided funding for GA facilities fees in conjunction with the ministry's Dental Program. In 2001/02, expenditures on this program peaked at $1M. While certain restrictions were in place, costs demanded by the dozen or so private GA facilities went largely unchecked. In some cases, fees were in excess of $400 per hour, for strictly the use of the privately owned operatory. In 2001/02, 2,200 MHSD patients were treated through these facilities. The average cost per client was $454.

- In 2002, MHSD decided to transfer responsibility for GA funding over to the CWHC. For fiscal 2003, MHSD made a permanent budget transfer of $1million to CWHC through MHS for the provision of GA services. Provision of GA services through the CWHC allowed for improved contract administration, a tendered bid process, establishment of standardized rates for services, implementation of strict clinical standards, development of a needs-based patient referral process and corrected the inequity created by MHSD clients receiving better service than the general public.
- In 2003/2004, the Community Dental Partners Program through the CWHC served 1,465 MHSD client 1,231 children and 234 PWD with cumulative facility fees paid totaling $578,720. The average cost per client was $395.
- A competitive tender process for 2004/2005 and 2005/2006 was successfully completed, with the establishment of seven service agreements - Comox Valley, Burnaby, Vancouver, Kamloops, Langley, Prince George and Abbotsford. At this time, rates increased from $320 per hour to $348 per hour plus a $50 perioperative fee. GA facility owners in Victoria and Nanaimo who had previously provided services chose not to bid on the new contract. CWHC realized that there was a potential service gap for central and south island patients, and retendered for that region only. The Nanaimo group continued to not respond, and the Victoria clinic counter-proposed for $540 an hour plus a $50 perioperative fee. In light of this, BCCH/PHSA negotiated with the Comox Valley provider for increased patient capacity and a higher contract allocation to serve patients from Central/South Island.
- Since 2006, GA facility contracts outside the lower mainland have been lost. Currently, there are only four facilities under contract:
  - Dr Kahwaji, Burnaby
  - Blaylock Surgical Centre, Abbotsford
  - South Fraser Surgical Centre, Abbotsford
  - Langley Surgical Centre, Langley
- When there is no private GA facilities available, GA under dental must be performed in a hospital.

s.13

Issues

- In early 2009, a client was treated at a private GA facility that no longer had a contract with the CWHC. The client's parents paid the GA fees. The dentist who performed the treatment requested that they be reimbursed for the extra $500 of dental performed under GA. Since the GA facility in question was not 'accredited' by the CWHC, they were not eligible and an exception had to be made.
- The BCDA has requested that the extra dental limit for treatment under GA be expanded to include treatment under IV sedation in any private dental office. The MHSD fee guide provides for the dentist's costs of IV sedation although the BCDA feels this amount is too low.
- The BCDA estimates that it costs $2,000 - $3,000 for GA services in hospital but the cost is only $515 for IV sedation in a private facility. Pressure on the health care system will also be relieved by reducing demand on operatory time.
- The BCDA has requested higher dental limits for dental performed under sedation – especially for children. The suggested limit for dental performed under sedation is

$1700. A higher sedation limit will allow more work to be completed in one sitting, resulting in fewer GA procedures per patient. Fewer GA procedures are healthier for the patient and save the health care system significant expenditures (OR time, various medical professional's time, shorter waitlists). Currently, many dentists will perform additional services for patients free of charge to avoid future GA procedures.

- There is a significant amount of work required by dentists prior to performing dental treatment under GA including administrative work such as obtaining consent. In order to address this, MHSD has included a pre-anaesthetic work-up fee in the fee guide. However, many dentists will not claim this amount because they do not want to use up any of the client's dental treatment limit.
- Diagnosis of PWD who require dental treatment under GA is often very difficult without sedating the patient. As a result, dentists are often faced with the situation of not knowing what dental care will be required. This can result in dental treatment plans changing on the fly. Changing a dental treatment plan often means obtaining new consent. Since consent for PDD comes from the caregiver, the dentist must rush new consent by the caregiver, all while the patient is under expensive GA.
- It should be noted that a dentist can exceed the basic dental limit as well as the additional $500 under GA limit if some of the procedures can be billed under emergency dental if they are for the relief of pain (although this is administratively cumbersome for dentists and contractors).

s.13

Allow dental hygienists to bill MHSD's dental plan

The BC Dental Hygienists' Association (BCDHA) represents over 2000 dental hygienists in British Columbia. According to the BCDHA, there are 30 independent dental hygienists in BC working in nine stand-alone practices. Of these 30, many provide mobile services in residential care facilities.

Ontario and Alberta are the only other provinces that allow dental hygienists to have independent practices. These provinces allow independent hygienists to bill their provincial dental plans. Many private insurance carriers also allow independent hygienists to bill their plans.

The BCDHA has requested that MHSD allow registered independent dental hygienists to be direct service providers under MHSD's dental plan. Currently, independent hygienists must bill through a dentist's office when treating MHSD clients. Under MHSD regulation, the ministry only accepts fee-for-service billings directly from dentists and denturists.

There are several benefits to allowing independent hygienists to bill MHSD's dental plan:

- The BCDHA has stated that some independent hygienists would be willing to accept MHSD's current fee schedule without balance billing the difference.
- Many independent hygienists are in a good position to provide care in remote areas because they already have mobile equipment for use in residential care homes.
- Additional dental service providers will improve client access to dental care.
- Greater client access to the preventative services offered by independent hygienists will improve short and long term dental health outcomes.

PBC administers MHSD's dental plan. As of February 1st, 2009, independent hygienists can now bill through other PBC dental plans. This development makes it relatively easy to modify the PBC system to allow hygienists to bill MHSD's plan.

PBC has produced a schedule of Hygienist Fee Codes. This schedule lists the procedures independent hygienists are permitted to bill for:

- Most Radiographs
- Periodontal treatment including scaling, root planing and polishing
- Sealants
- Recementation of crowns or bridge abutments.

It would be beneficial for MHSD to limit the items independent hygienists can bill for to those outlined in PBC's Hygienist Fee Codes. All fee codes selected are within hygienist scope of practice, are already part of the dental fee guide and hygienists are already able to bill these codes through dental offices. Some hygienist fee items such as dental assessments and oral hygiene instruction are not currently part of PBC's fee guide or PBC's new schedule of Hygienist Fee Codes. The rates and frequencies for these items would be the same as in MHSD's dental plan.

s.13

Not Responsive

Not Responsive

OPTIONS:

s.13

Pages 88 through 91 redacted for the following reasons:
- -
Section 13

s.13

Dentures and s.13

s.13

Option 2: Adjust denture and s.13 rates to match the 2009 PBC fee schedule and adjust available denture services.
Implications:

- Not Responsive

- Only actual dentures and s.13 will receive the fee boost – not relines, repairs or other denture and s.13 related procedures.
- Denturist rates will be increased to 80% or less of the 2009 PBC guide – consistent with the current ratio between dentist and denturist rates. Some procedures in the denturist's guide may still be less than 80% of the PBC guide – if this is the case, these fees will be matched.
- Combined rates for both upper and lower dentures will be included. The combined rates fee codes in the PBC guide provide on average a 4.5% discount over providing upper or lower dentures separately.
- s.13
- Policy and regulation changes required.
- The BCDA and denturists will be pleased with these changes as they will no longer be out of pocket for lab fees (although still not receiving as much as they might like).
- Clients will find it easier to secure treatment.

s.13

s.13

s.13

s.13

Option 3: Maintain children's limit but change to $1400 every two years
Implications:

- Expenditures are likely to be neutral or even result in longer term cost savings. Expenditures will increase at first because of the higher limit available, but children will require less treatment over time.
- Some children require a large amount of dental treatment over a short period of time to deal with accumulated problems. After the initial dental work is completed, treatment need usually drops and remains low. Ideally, subsequent dental treatment is limited to preventative services.
- Providing a large amount of dental treatment all at once, addressing all dental problems with permanent solutions is more efficient than several temporary fixes over a number of years (temporary fixes may be all the current $700/year limit will allow).
- Emergency dental will still be available to address emergency dental needs.

s.13

s.13

GA Facilities

s.13

s.13

Option 5: Increase the extra dental limit for treatment under sedation from $500 to $1000.
Implications:

- Not Responsive
- Will help provide additional dental coverage for clients with PDD and other clients in need.
- Reduces the need for repeat appointments under GA. Repeat GA appointments can compromise a client's health and result in significant costs – administrative, assessments, medical specialists, etc.
- Addresses the request from the BCDA and allows for more efficient provision of dental services.
- Currently, dentists can bill above the extra $500 if some of the procedures can be billed under emergency dental for the relief of pain.
- Policy and MHSD fee guide update required.

s.13

Allow dental hygienists to bill MHSD's dental plan

s.13

Option 2: Allow dental hygienists to bill MHSD's dental plan limited to the services listed in PBC's Hygienist Fee Codes (This option has been recommended, pending OIC approval).
Implications:

- Independent Hygienists through the BCDHA will need to agree to limit the services they provide under MHSD's dental plan to those listed in PBC's Hygienist Fee Codes. Initial conversations with the BCDHA indicated this would be acceptable; however, further discussion is needed.
- MHSD client access to dental services will be improved.
- Regulation and policy changes will be required.

s.13

Not Responsive

Consultations:
Marianne Love, Senior Adjudicator, HAB
Pam Christenson, Senior Policy Advisor, SPRB
Brad Truswell, Provincial Services EAW, Provincial Services Contact Centre

Enclosures/Attachments:
Appendix A - *History and Overview of Dental*
Appendix B - D*ental Program Comparisons*

Approved/Not Approved Date:

_____ _____

Rob Bruce
Executive Director
Strategic Policy and Research Branch

PREPARED BY:	**REVIEWED BY (please initial):**		DATE:
Erik Bekker Policy and Research Analyst Strategic Policy and Research Branch (250) 387-7005	Dana Jensen Manager Strategic Policy and Research Branch	_____	_____
	Alison Bath Director Strategic Policy and Research Branch	_____	_____

Appendix A - History and Overview of Dental

Prior to 1980

- MHSD (MHSD refers to MHSD as well as precursor ministries), independently adjudicated each dental bill. No fee schedule was used.

1981

- The Ministry of Health (MoH) introduced the Dental Care Plan of BC and absorbed MHSD clients. Fees were paid in accordance with the BC Federation of Dental Societies' (Federation) fee guide.
  - All recipients of premium MSP assistance and all Human Resources clients received 100% coverage of basic dental and dentures up to a maximum of $700 per year.
  - All senior citizens and children 14 and under received 50% coverage of basic dental and dentures up to half of $1400 per year.
  - All children were additionally covered 100% for preventative care.

1982

- MoH moved away from the Federation fee guide and payment for services varied. This was the beginning of the government fee guide. Some services were reimbursed at a greater amount than the Federation fee guide, although on average, 100% of the Federation fee guide was paid.

1983

- Dental Care Plan terminated due to unsustainable cost. MHSD resumed role of provision of dental services to MHSD clients. MoH's dental rules and fee schedule were adopted.

1984 to 1986

- No negotiations, discussions or adjustment to the fee schedule occurred.

1988

- Increase to MHSD guide of 6.9% (95% of Federation guide covered). $19.5M spent on dental program.

1989

- Increase to MHSD guide of 3.0%. $20.5M spent on dental program.

1990

- Increase to MHSD guide of 2.5%. $21.5M spent on dental program.

1991

- Increase to MHSD guide of 6.5% (88% of Federation guide covered).
- $23.5M spent on dental program.

1992

- Increase to MHSD guide of 2.25% $28.0M spent on dental program.

1993

- Increase to MHSD guide of 1.5% $30.0M spent on dental program.

1994

- Increase to MHSD guide of 2.0% $34.0M spent on dental program.

1995

- Increase to MHSD guide of 2.0% (Part of a retroactive 8.0% total increase since 1992). 85% of Federation guide covered. $37.6M spent on dental program.
- Serious negotiations between the Federation and MHSD to try and reach a new contract – the existing contract included a guarantee of MHSD client treatment without balance billing. Government offered a 5.5% cumulative retroactive increase. The Federation offered 11.75% plus a commitment to further increases. Both offers were rejected by each party. In an effort to try and fund a fee increase for dentists, MHSD and the Federation agreed to investigate ways in which savings could be found within the dental program.
- Last contract with BC dentists expired on December 31, 1995

1996

- 83% of Federation guide covered. Dental budget $50.4M – $14.7M for Healthy Kids.
- Negotiations to reach a new contract continued. The Federation asked for a 15% increase of fees to bring Federation fees to 95% of the Federation fee schedule. The Federation viewed this proposal as an interim step towards a 20% increase covering 100% of their fee guide. MHSD countered with a 1% fee increase. The Federation felt any offer outside the 15% range was unacceptable.
- MHSD decided to reduce the dental limit for some adults from $500 to $250 and use the savings to fund a dental program for children (Healthy Kids). Dentists felt that they should have shared in these savings through a fee increase and did not welcome the new children's program at the same low rates. The Federation proposed further costs saving ideas totalling approximately 10% - towards the goal of applying the savings to fees.
- In March 1996, the Federation sent a memo to dentists explaining that a resolution had been passed recommending that all dentists begin balance billing MHSD clients and recommending that dentists inform MHSD clients of this decision. The memo also reminded dentists of their ethical responsibilities if they decided to stop accepting the MHSD plan or intended to limit MHSD clients (ethical responsibilities include emergency treatment). At the time, balance billing was contrary to MHSD policy.
- In June 1996, the Federation sent another memo to dentists urging them to withdraw service in order to pressure government into adjusting fees. Despite this urging, dentists largely continued to treat MHSD clients – especially in urban areas. In small towns and rural areas, dentists withdrawing services had a larger impact. That was the genesis of current MHSD policy – dentists are allowed to balance bill but are encouraged to consider their social conscience.

April 1996

- Program consists of:
  - Basic dental (services outlined in fee schedule)
  - Preauthorized dental (services in excess of limit or a service outside of fee schedule)
  - Emergency dental (immediate relief of pain – Emergency Dental Form)
- Introduction of the Healthy Kids Program
- $500/year of dental coverage for children (0 to 12 years of age) whose parents receive premium assistance through MSP. 50% fee coverage for children in families receiving partial MSP assistance. 100% fee coverage for families receiving full assistance.
- $700/year of dental coverage introduced for children of employable clients
- Adult annual limits reduced from $700 to $500 for DBII and seniors and from $500 to $250 for DBI and other eligible adults (19-64)

January 1997

- Healthy Kids Program expanded to include children 0 to 18 years of age and limit increased to $700 per calendar year

1998

- BC Dental Association formed – replacing the BC Federation of Dental Societies
- MHSD operated a dental van in the spring and summer of 1998 and 1999 which traveled to British Columbia's northern communities and provided dental service to MHSD clients and other British Columbians in need – especially children. The van was successful in reaching children who rarely accessed dental treatment.

May 2001

- Healthy Kids expanded so that all children receive 100% coverage
- In 2001, responsibility (budget) and administration of dental for children in care was transferred from MHSD to the Ministry of Children and Family Development.

July 2002

- Fee Schedules were regulated
- Basic dental eliminated for some client groups (e.g., single parents)
- Preauthorized dental eliminated, including basic dental services over the annual limit
- The Emergency Dental Fee Schedule introduced replacing the Emergency Dental Form
- Complete dentures (initial placement) coverage extended to all clients if dentures are required as a result extraction for the relief of pain that result in full arch clearance and extractions took place within the last 6 months
- Partial dentures (initial placement in excess of the annual limit) coverage limited to clients eligible for Schedule C who have had at least one extraction in the preceding 6 months that resulted in 3 or more adjacent missing teeth on the same arch and the ministry has not paid for a denture within the previous 5 years.
- Replacement dentures (in excess of the annual limit) – coverage limited to clients eligible for Schedule C who have had 2 years of continuous ministry coverage and who have not had dentures provided in the last 5 years.
- Access to an additional $500 of basic treatment provided for children or disabled adults that require treatment under GA/IV sedation in hospital or private facilities.
- The criteria for Orthodontic coverage was redefined to focus limited resources on individuals with the most severe need – those persons who have severe skeletal dysplasia with jaw misalignment by two or more standard deviations

April 2003

- In 2002, MHSD decided to transfer responsibility for GA funding over to the Children's and Women's Health Centre (CWHC). For fiscal 2003, MHSD made a permanent budget transfer of $1million to CWHC through MHS for the provision of GA services.

September 2003

- Two-year limit introduced for PWD, PPMB MSO's and spouse of PWD to allow more flexibility in use of dental limits

December 2003

- Crown and bridge supplement introduced for PWD and PPMB clients
    - Specific criteria must be met and preauthorization required
    - Requests are submitted to PBC for review by their dental consultant

April 2005

- Increase to dental fees- from 63% to 80% of 2004 BCDA Fee guide
- Fee increase was co-funded by MoH
- Standardized fee codes/services; adjudication rules were reviewed and brought in line with PBC's regular book of business rules where possible
- Updated MHSD Fee Schedule released – First one in ten years
- Limits for all adults eligible for basic dental increased to $1000/2 years
- MHSD's Denturist Fee Schedule also updated with increased fees and addition of partial dentures. The addition of partial dentures aligned with denturist's previously expanded scope of practice.
- Both fee schedules in regulation

January 2007

- 2 percent increase to fees for dentists and denturists
- Fees brought to 74 percent of 2007 BCDA Fee Guide

- New Fee Schedules released with minor changes to adjudication rules (e.g.: eliminated limit on # of extractions per emergency visit

April 2007
- Basic dental coverage at $1000/2 years extended to spouses of PPMB

February 2008
- Policy amended on eligibility of members of a family unit containing PPMB to be consistent with Regulation.

August 2008
- Health Assistance Branch may authorize exemptions to the once every five years replacement policy for dentures

Dental Supplement 2009 Policy

- MHSD fee guide, on average, covers 67% of BCDA guide

Emergency Dental Services
Eligible Clients:
- Recipients not eligible for basic dental services, including hardship assistance
- Recipients eligible for basic dental services who have reached their limit (annually for children, every two consecutive years for adults)
- Persons over 65 who are not eligible for general health supplements

Basic dental services: $700 per calendar year
Eligible Clients:
- Dependent children of income assistance and disability assistance recipients
- Recipients of child in the home of a relative (CIHR) assistance
- Dependent children of families receiving premium assistance through Medical Services plan (Healthy Kids)

Basic Dental Services: $1000 every two calendar years
Eligible Clients:
- Recipients with the PWD designation
- Recipients with the PWD designation who left for employment or federal programs (MSO)
- Persons over 65 with the PWD designation
- Persons with persistent multiple barriers (PPMB)
- Spouses of recipients with the PWD designation
- Spouses of persons with PPMB
- Persons over 65 eligible for general health supplements but without the PWD designation

Crown and Bridgework
Eligible Clients
- Recipients with PWD designation
- Recipients eligible for PPMB-
- If the dental condition cannot be corrected through the provision of basic dental services and one or more of the following circumstances exist:
  - The dental condition precludes the use of removable prosthetic
  - The person has a physical impairment that makes it impossible for the person to place a removable prosthetic
  - The person has an allergic reaction or other intolerance to the composition or material used in a removable prosthetic
  - The person has a mental condition that makes it impossible for the person to assume responsibility for a removable prosthetic
- Requests for crown and bridgework are initiated by the dental practitioner and are sent directly to the ministry contractor (PBC) for adjudication. There is no requirement for field staff involvement in this process.

General Anaesthetic or intravenous sedation
- General anaesthetic or intravenous sedation performed in a dental office may be provided in the following situations:
  - For children under 19 where necessary for the safe performance of dental treatment
  - For children and adults with the PWD definition with severe mental or physical disabilities that necessitate general anaesthetic/IV sedation

- The Provincial Health Services Authority (PHSA) manages general anaesthetic or intravenous sedation at private facilities through the Children's and Women's Health Centre (CWHC). The determination of eligibility for general anaesthetic or intravenous sedation at private facilities is between the dentist and the CWHC.
- Children and adults with the PWD designation who require anaesthetic in a hospital or private facility may access an additional of $500 of basic treatment.

Dentures- Complete dentures (single or both arches)

Eligible Clients:

- All recipients (including those with emergency coverage only) if there have been extraction within the last six months that result in full clearance of the arch

Partial dentures in excess of the basic dental financial limit

Eligible Clients:

- Recipients with the PWD designation and spouses
- Recipients eligible for PPMB and spouses
- Children

If the ministry has not paid for a denture on the same arch within the past five years and there has been at least one extraction in the last six months that results in three or more adjacent missing teeth

Replacement dentures (partial or complete) once every five years

Eligible Clients:

- Recipients with the PWD designation and spouses
- Recipients eligible for PPMB and spouses
- Children

If the recipient has been in receipt of income assistance or disability allowance for at least two years

Orthodontic services

Eligible Clients:

- Dependent children of income and disability assistance recipients
- Recipients with the PWD designation
- Recipients of *CIHR*

If the recipient has severe skeletal dysplasia with jaw misalignment by 2 or more standard deviations

APPENDIX B – Dental Program Comparisons

Simplified comparison between the BC Public Service plan and the dental plan for MHSD clients		
	BC Public Service plan	MHSD client dental plan
Basic Dental Services – those services routinely available in dental offices	Covered at 100% subject to frequency limits.	Subject to a limit of $700 per year for children and $1,000 per 2 years for PWD and PPMB adult family members. Subject to frequency limits. Emergency dental is available for the immediate relief of pain or if a person's health or welfare is immediately jeopardized.
Crown and bridge work	Covered at 65%, once every 5 years.	Available to some PWD and PPMB clients with certain conditions that cannot be corrected through basic dental services. Paid in excess of the patient's basic dental limit.
Orthodontic services	55% covered to a total lifetime maximum of $3,500	Available to PWD clients and children who have severe skeletal dysplasia with jaw misalignment by 2 or more standard deviations.

General anaesthetic or intravenous sedation	General anaesthetics are not covered	Provided through the provincial Health Services Authority and covered by MSP, when necessary, for PWD and children. Clients who require anaesthetic may be eligible for an additional $500 of basic dental treatment annually.
Complete dentures	Covered at 65%, once every 5 years only.	Recipients (including those with emergency coverage only) if there have been extractions within the last six months that result in full clearance of the arch.
Partial dentures	Covered at 65%, once every 5 years only.	Available to PWD and PPMB recipients and their spouses; children. If the ministry has not paid for a denture on the same arch within the past five years and there has been at least one extraction in the last six months that results in three or more adjacent missing teeth.
Replacement dentures (partial or complete)	Covered at 65% as required, provided that they are not of a temporary nature	Available to PWD and PPMB recipients and their spouses; children. Frequency is once every five years. Health Assistance Branch may authorize exemptions to the once every five years replacement policy if certain criteria are met.

INTER-JURISDICTIONAL COMPARISON

Canada – Dental Coverage

Health Canada's Non-Insured Health Benefits (NIHB) program for Status First Nations and Inuit

- The dental component of the Non-Insured Health Benefits (NIHB) Program covers dental services, including: diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery, orthodontic and adjunctive services.
- Coverage for dental services is determined on an individual basis, taking into consideration the current oral health status, past client history, accumulated scientific research, and availability of treatment alternatives.
- Certain services may need predetermination/prior approval
- There is no dollar maximum for treatment – only prescribed frequencies.
- Reimbursement rates are sometimes the same and sometimes less than those outlined in provincial dental association fee guides.

Alberta – Dental Coverage

Income Assistance Recipients

Two types of dental coverage are available:

1) Standard Dental Coverage provides basic services such as extractions and fillings to alleviate pain and infection. Denture coverage is also available. If the dependent is a child, some additional services such as cleaning and annual examinations are covered for the child only.
   Expected to work and learner households receiving income support are eligible for standard coverage. It is also available as a one time issue for transient and resident

sub-types. The high prescription drug needs sub-type falls under this level of coverage, as well.

2) Supplementary dental coverage includes what is offered under standard coverage while also addressing some long term needs (such as annual examinations for adults).
   This coverage is offered to not expected to work households who are receiving income support. It is also available for the pregnancy sub-type.

Those who are leaving income support (and their dependents) for one of the following are entitled to the Alberta Health Benefit (AAHB), subject to income testing:

- employment (if they are an expected to work client with children)
- employment (if they are a not expected to work client)
- Canadian Pension Plan – Disability (CPP-D) program (if severely disabled and a not expected to work client)

Under the AAHB, former IS recipients are eligible for the same level of coverage as they were when they were recipients. Eligibility is reviewed each September, to ensure clients are still below the qualifying income threshold.

Children

Under the Alberta Child Health Benefit (ACHB), children of families with limited incomes are eligible for premium free health benefits. Children under 18, as well as 18 & 19 year olds, who are still attending school and living at home, are included.

- Dental coverage for children includes one yearly examination and cleaning as well as other necessary dental care required for good oral health (such as fillings and extractions, X-rays). Household income is reviewed annually and children will be automatically re-enrolled if they are eligible.

Seniors

Basic dental services are provided for low- to moderate-income seniors receiving financial assistance. Under the Dental Assistance for Seniors program, examinations, cleanings, fillings, extractions, root canals, and basic dentures may be covered. Alberta Blue Cross is contracted by Alberta's Seniors and Community Supports to process the dental benefits (with a maximum coverage of $5,000 every 5 years).

Determining Coverage

The Alberta Dental Association and College does not publish a fee guide. Instead, insurers establish their own reimbursement levels for dental services. Coverage for specific dental goods and services is defined by agreements between Alberta Employment and Immigration and the Alberta Dental Association and College. Claims are administered and adjudicated by the Alberta Dental Service Corporation (ADSC). The ADSC provides payment for dental professionals for services provided to all Income Support recipients.

Saskatchewan – Dental Coverage

Income Assistance Recipients

Clients are nominated for the Supplementary Health Program through the Saskatchewan Assistance Program. Those eligible will receive a Supplementary Health Card which can be used to obtain health services and products, including dental care.

Two benefits levels are provided:

1) Emergency Benefits are provided for employable adults (and their spouses) who are receiving financial assistance. Benefits are provided for 6 months and are limited to pain relief and infection control.

2) Full Benefits are extended to employable adults following the 6 months of Emergency Benefits. Partially employable and unemployable clients are eligible for Full Benefits, as well as dependent children, who automatically qualify. Coverage includes that which is required to maintain good oral health (i.e. examinations, x-rays, cleaning, restoration, extractions, and dentures). However, dentures are only partially covered, requiring the client to pay a portion. Clients also have the option to upgrade from amalgam to composite fillings and from acrylic to cast metal partial dentures (at partial cost to the client).

Children
Family Health Benefits are provided by the Government of Saskatchewan to help lower income families with the costs of raising health children. Eligibility is based on the number of children and the family's annual income. Children under 18 years of age are targeted and provided with partial coverage for basic dental services.

Determining Coverage
Ideally, fees are to be negotiated yearly with the Saskatchewan Dental College. Currently, coverage is 90 percent of the College's fee guide.

Manitoba – Dental Coverage

Income Assistance Recipients
Manitoba Family Services and Housing provides dental assistance for EIA participants. Basic dental coverage is provided dependent children, single parents, and PWDs that have been in the EIA program for a period of at least 3 months. Single adults or couples without disabilities must have been in EIA for 6 months before being eligible for dental benefits. However, emergency dental coverage for pain relief does not require a wait period. Eligibility may also be established as a one time payment to assist with dental care if one is not in receipt of EIA but cannot afford to pay.

A 12 month maximum of $500 per adult or child for restorative procedures has been established. There is no limit for extractions, though a 12 month frequency limit has been established for examination, cleanings, and x-rays (partial or complete dentures every 6 years).

Seniors
The Government of Manitoba recommends the Faculty of Dentistry (University of Manitoba) in its Manitoba Seniors' Guide 2008/2009. The University operates 11 clinics for teaching purposes with reduced fees (approximately 50 percent of the Manitoba Dental Association Fee Guide). The clinics' services are directed at underserved and vulnerable population (low income seniors, disabled, and First Nations).

Determining Coverage
The Government of Manitoba negotiates annually with the Manitoba Dental Association to set dental services and fees. It currently pays 90 percent of the MDA fee schedule for agreed upon items of service for IA recipients.

New Brunswick – Dental Coverage

Income Assistance Recipients
The Health Services Dental Program assists clients of Family and Community Services (and their dependents) with specific dental services. As a last resort, the following services are covered:

- diagnostic services
- preventative services
- restorative services
- endodontic services
- periodontal services
- prosthetic services
- surgical services
- additional services

Determining Coverage
The Government of New Brunswick negotiates with the New Brunswick Dental Society and the New Brunswick Denturist Society to set dental fees. As of 2008, coverage for dental services was at 80% of the Dental Fee Guide.

Newfoundland and Labrador – Dental Coverage

Income Assistance Recipients
Adults (18+) receiving social assistance are entitled to emergency examinations (for pain, infection, and trauma) and extractions.

Under the Social Assistance Dental Health Program, dental care is provided to children (13 to 17 years) of families receiving income assistance. Coverage is as follows:

- examinations (every 24 months)
- X-rays (with some limitations)
- routine fillings and extractions
- emergency examinations (pain, infection, or trauma)
- may consider an amount towards the cost of dentures in certain circumstances

Children
The Children's Dental Health Program, (provided by the Department of Health and Community Services), provides dental coverage for all children under 12 years of age. Coverage is as follows:

- examinations (every six months)
- cleanings (every 12 months)
- fluoride applications for ages 6 to 12, every 12 months (except where School Rinse Program is in place)
- X-rays (with some limitations)
- routine fillings and extractions
- sealants

Nova Scotia – Dental Coverage

Income Assistance Recipients
Those receiving financial assistance may be eligible for emergency dental care under certain circumstances (pain, uncontrollable bleeding in mouth, swollen gums, dentures that need fixing, dental problems that could stop one from getting a job).

The Government of Nova Scotia provides clients with the Employment Support and Income Assistance Dental Program. Eligible clients (and their dependents) will receive emergency

dental care, some diagnostic, preventative, restorative, prosthodontic, endontic and pre-approved oral surgery services.

Eligibility is income tested and dependent upon household number and probability of employment. Those who are eligible will receive coverage for 80 percent of the costs. The program is centrally administered.

Children
Under the Children's Oral Health Program (COHP), children under the age of 10 years receive coverage as a last resort. Clients are required to seek out private coverage first (COHP will pay the balance). Diagnostic, preventive, and treatment services will be provided.

Administration for the diagnostic, preventive, and treatment component is conducted by Medical Services Insurance (MSI). Adjudication and payment is contracted to Quikcard Solutions Inc. (QSI).

Ontario – Dental Coverage

Income Assistance Recipients
Under Ontario Works, adults may be eligible for Health Benefits including emergency dental care that supports the person's employability or participation requirements (i.e. orthodontic or denture services).

Extended Health Benefits may be offered if the recipient is no longer eligible for Ontario Works and are facing high health (dental) costs.

The Ministry of Community and Social Services also provides basic dental coverage for clients of the Ontario Disability Support Program. Additional dental services may be provided if the client's disability, prescribed medications or prescribed treatment affects their oral health

Children
The Children in Need of Treatment (CINOT) dental program provides coverage for children (birth to grade 8 or 14 years) with a dental condition that requires urgent care. Eligible recipients do not have access to dental insurance or any other program and the cost of the necessary dental treatment would result in financial hardship for the parent(s). As of January 2009, CINOT expanded to cover children up to the age of 18 years. CINOT covers a range of basic dental services, though not all services recommended by a dentist (such as braces for teeth straightening).

The Ontario Cleft Lip and Palate / Cranial Facial Dental Program provides up to 75 percent coverage for pre-approved dental specialist treatment costs that is not covered by dental insurance, (or 75 percent of approved estimate). Eligibility for this program is based on possession of valid OHIP number, diagnosis, and program registration prior to eighteenth birthday).

Seniors
Some Ontario municipalities provide subsidized dental care for seniors. There are also several Ontario universities and colleges that have dental clinics which are open to the public, offering services at reduced fees.

Prince Edward Island

Income Assistance Recipients

Community Dental Services is a pilot project providing volunteer dental care for lower income adults. It is a first-come first-serve one-time-only course of treatment. Eligibility is based on income and lack of any other dental benefits or insurance. There is a $20 registration fee, as well as any lab costs that are incurred. Coverage is as follows:

- complete dental examination and consultation
- preventative services including oral health information, cleaning and scaling, and dental sealants where indicated
- basic fillings in front and back teeth

Children

The Children's Dental Care Program (CDCP) is provided to all children between the ages of 3 and 17 years inclusive (given that they are residents of PEI and have a PEI Medicare Personal Health Number). There is a $15 yearly cost per child (maximum of $35 per family) and 20 percent parent contribution towards treatment fees (fillings, extractions, etc., but not of examinations or preventive services). Families with a low net income can apply for an exemption from the 20 percent parent contribution. If eligible, the family will receive a card, verifying eligibility that will be valid for 12 months at which time it will be necessary to re-apply for the exemption. Most basic dental services are covered:

- examinations and X-rays (once every 12 months)
- preventative services (oral hygiene instruction, cleaning, scaling, fluoride application, and dental sealants)
- amalgam (silver) or composite (tooth coloured) fillings on back teeth
- tooth coloured fillings on front teeth
- stainless steel crowns
- extractions
- root canal fillings on permanent front teeth
- emergency services
- limited orthodontic services

Seniors

The Long Term Care Facilities Dental Program provides residents of provincial and private seniors' manors with annual screenings and in-house preventive services. There is no cost for screenings or preventive services, however, treatment services (fillings, extractions, dentures) are at their expense.

Quebec – Dental Coverage

Income Assistance Recipients

Every Health Insurance Card holder is entitled to certain oral surgery services in the event of a trauma or illness, along with necessary examinations, local or general anesthesia, and x-rays.

Recipients of last-resort financial assistance (for at least 12 consecutive months) and their dependents are entitled to the following in hospitals or dental clinics:

- one examination per year
- emergency examinations
- X-rays
- local or general anaesthesia
- amalgam (grey) fillings for the posterior teeth

- fillings using aesthetic materials (white) for the anterior teeth
- prefabricated crowns
- sedative dressings, i.e. temporary fillings intended to reduce pain
- certain root canal treatments, such as pulpectomy, pulpotomy, and emergency opening of the pulp canal
- tooth and root extractions
- the oral surgery services covered for all
- root canal and apexification treatments (before age 13)
- cleaning of teeth and teaching hygiene procedures (from age 12)
- application of fluoride, age 12 to 15 inclusive
- scaling, from age 16

In emergencies only – for persons who have been recipients of last-resort financial assistance for at least 12 consecutive months:

- tooth and root extractions
- opening of the pulp chamber
- drainage of an abscess
- hemorrhagic control
- repair of a laceration
- reduction of a fracture
- immobilization of a tooth loosened by trauma
- re-implantation of a tooth

Recipients of last-resort financial assistance (for at least 24 consecutive months) are entitled to the same coverage as those of at least 12 months as well as the following:

- one lower dental prosthesis and one upper acrylic dental prosthesis every eight years
- one recoating every five years
- half the cost of replacing lost or damaged dental prosthesis
- replacement of prosthesis following surgery
- repair of prosthesis
- addition of a structure

(does not include coverage for removable partial dentures with a metal framework)

Children

The Government of Quebec provides the following for children under 10 years:

- one examination per year
- emergency examinations
- X-rays
- local or general anaesthesia
- amalgam (grey) fillings for the posterior teeth
- fillings using aesthetic materials (white) for the anterior teeth
- prefabricated crowns
- sedative dressings, i.e. temporary fillings intended to reduce pain
- endodontics (including, in their case, root canal treatment, apexification, pulpectomy, pulpotomy, and emergency opening of the pulp canal
- tooth and root extractions
- oral surgery services provided for all

(teeth cleaning and application of fluoride for children under 10 are excluded)

United States

- Clinical oral health care is predominantly provided by a private-practice dental workforce in both the United States and Canada. In both countries government has tried to reduce dental health disparities through targeted, as opposed to universal, programs.
- American federal and state assistance programs — Medicare, Medicaid, the Children's Health Insurance Program, the Indian Health Service and other programs for selected oral health services — exist for all indigent and medically indigent persons, children, elderly people, people with disabilities, Native Americans and Alaskan Inuit.
- Not only are these programs limited in scope, but their reimbursement levels are low relative to the usual fees for care.
- A 2001 U.S. Surgeon General's Report on Oral Health in America found the U.S. public health infrastructure for oral health was insufficient to address the needs of disadvantaged groups.

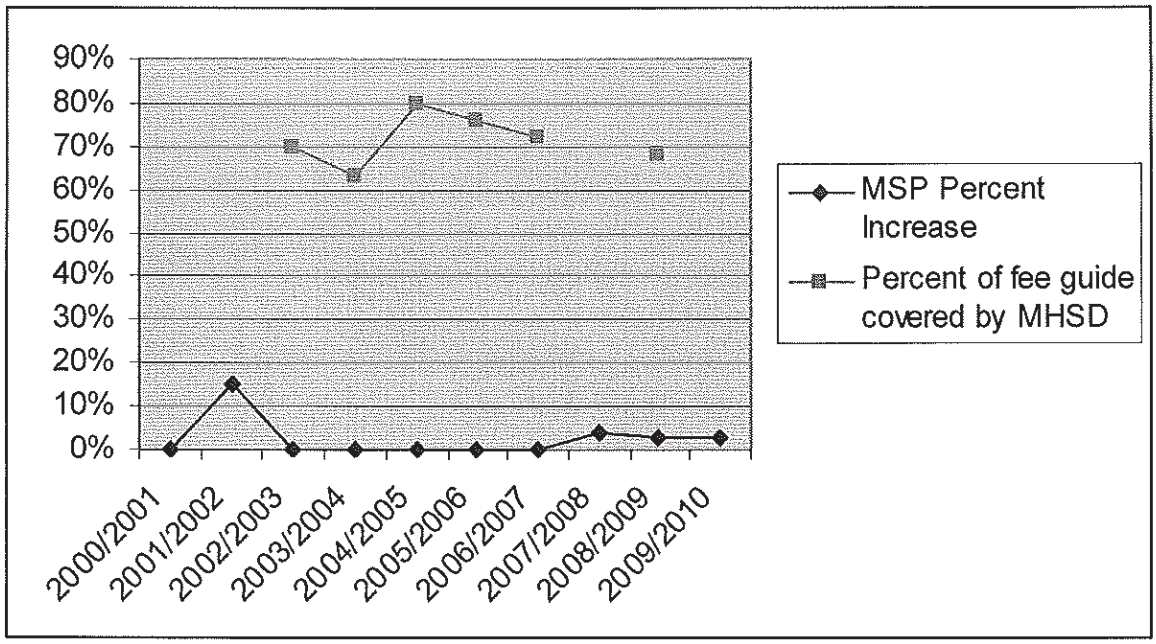
Washington State

- Washington has one of the more generous Medicaid dental benefits in the United States. Half of all states provide no dental coverage at all or limit coverage to cases of severe pain or trauma. Unlike with children, states do not have to provide Medicaid dental coverage for adults. The savings came largely from eliminating coverage for many root canals and crowns.
- Washington's Medical Assistance programs provide healthcare coverage including dental for low-income residents who meet certain eligibility requirements. These include, but are not limited to age, pregnancy, disability, blindness, and old age. Special rules exist for those living in a nursing home and disabled children living at home. Eligibility for Medical Assistance is determined at the local Community Service Office.
- A majority of dentists in Washington won't accept Medicaid because of paperwork and because Medicaid pays 30 percent or less than private insurers.
- Most Washington adults who qualify for Medicaid can get some free dental care, including checkups, cleaning and fillings. Clients with developmental disabilities may be entitled to more frequent services.

Client category	Basic dental services	Crowns/dentures
Alcohol and drug abuse treatment and support act	Restricted with coverage limitations	service is usually not covered
Categorically needy	Yes, service is usually covered	Restricted with coverage limitations
Medically needy	Yes, service is usually covered	Restricted with coverage limitations
State children's health insurance program	Yes, service is usually covered	Restricted with coverage limitations
General assistance unemployable	Restricted with coverage limitations	service is usually not covered

Comparison of Common Fees for MSP, MHSD and BCDA
MSP Fee Increases

	Fee Code	MSP	MHSD	BCDA
Extractions				
Removal of erupted teeth				
Uncomplicated				
First tooth	71101	$60	$69.02	$100.80
Each additional tooth per quadrant	71109	$39.54	$45.59	$66.50
Complicated				
First tooth	71201	$117.27	$130.29	$199.90
Each additional tooth per quadrant	17209	$83.14	$85.98	$149.90
Impacted teeth (Unerupted)				
Partial bone covered				
First tooth	72211	$135.17	$150.25	$232.90
Each additional tooth per quadrant	72219	$63.92	$99.17	$174.70
Complete bone covered				
First tooth	72221	$188.94	$209.96	$327.80
Each additional tooth per quadrant	72229	$94.68	$138.58	$245.90
Residual Roots				
Soft tissue coverage				
First tooth	72321	$71.83	$124.76	$176.10
Each additional tooth per quadrant	72329	$31.79	$88.84	$132.00
Bone tissue coverage				
First tooth	72331	$135.24	$143.78	$203.40
Each additional tooth per quadrant	72339	$50.52	$94.91	$152.50
Surgical Exposure				
Transplantation of erupted tooth	72611	$232.43	$307.62	$435.70
Periapical Services				
Apicoectomy				
Anterior One Root	34111	$218.34	$218.37	$308.00
Amputations				
One Root	34411	$193.12	$193.11	$273.10
Two Roots	34412	$231.73	$231.72	$328.10
Open and drain	39201	$63.65	$46.04	$64.70
Vestibuloplasty				
Per Sextant	73421	$297.18	$255.16	$361.40
Total		$2,308.49	$2,633.15	$3,933.40
Plan as a percent of MHSD fee schedule		**88%**		**149%**
Plan as a percent of BCDA fee schedule		**59%**	**67%**	
Plan as a percent of MSP fee schedule			**114%**	**170%**


90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2000/2001
2001/2002
2002/2003
2003/2004
2004/2005
2005/2006
2006/2007
2007/2008
2008/2009
2009/2010
MSP Percent Increase
Percent of fee guide covered by MHSD

Dental Supplements

Previous Policy	Changes made April 2010	Rationale
• MSD rates were 64% and 67% of the respective denturist and dentist denture fees; • Children's limit of $700 per year; • PWD and children under GA receive an extra $500 in dental work through an administratively complex process (most often in a hospital); • Polishing and topical fluoride are limited to twice per year; • Examinations are limited to twice a year; and, • $54.71 in x-rays every year.	• In recognition of increased laboratory costs, the ministry increased denture rates to 75% of the corresponding fee items in the 2009 Pacific Blue Cross fee guide (both dentist and denturist)*; • In order to provide more flexibility and efficiency to clients and dental care providers the ministry is moving to a $1,400 per 2-year limit for children; • The annual limit for dental care under general anaesthetic in hospital or an approved private facility will increase from $500 to $1,000; • Frequency of preventative services for all clients has decreased to once annually; • Coverage for radiographs has been reduced to $54.71 every two years; • Pathology reports for dental surgery are no longer required; and, • Independently practicing dental hygienists will now be permitted to bill the ministry's dental program. *Note: Due to two subsequent increases in fees made by both the dentists and denturists, MSD dentures fees are again below 70% of the 2011 PBC fee guide	• The dental program was restructured to ensure sustainability while making important improvements and balancing the needs of clients and the dental and health. • Savings from some of the reductions will be used to offset costs for denture fees and additional services while person is under anaesthetic. • Current coverage for general checkups is more generous than most private dental plans. The majority of clients access cleanings only once per year. Disabled adults with special needs requiring extensive cleaning still have access to other services such as scaling and root planning. • Increasing fees for dentures will improve service and access for ministry clients. Denture fees include laboratory costs which have increased without compensation to the dental profession. • Implementing a $1400 2-year limit for children ensures maximum flexibility in providing treatment. This is cost neutral over time, but allows dentists to address complex dental needs more effectively, with better long term outcomes for the child. Multiple treatments often result in poor outcomes and can be more costly over time.

April 15, 2011

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

DATE: August 28, 2009

PREPARED FOR: Robert Bruce, Executive Director

ISSUE: s.13 and Monthly Nutritional Supplements – Program Review

BACKGROUND:

Not Responsive

Not Responsive

Cliff# 153790
Version #
Updated:

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

Not Responsive

Monthly Nutritional Supplement

In 1996, Disability Benefits recipients living with HIV/AIDS began to request a monthly health allowance to assist with additional costs associated with their illness. The legal authority used for these requests was Schedule C, s.2 (1) (l) of the Disability Benefits Program regulation. This was a special clause that allowed the ministry to provide any health care good or service not provided elsewhere to anyone with a "life-threatening need" for which "no other source of funding was available". While the ministry denied these requests, recipients successfully appealed the denials and were awarded monthly cash allowances by the BC Benefits Tribunal Board.

Requests and awards typically included funding for the additional costs associated with a nutritional diet, vitamins, minerals and bottled water. However, some requests and awards expanded to include over the counter medication, a wide variety of complementary therapies and even items such as health club memberships, pet care and car insurance. Over the years, the amounts awarded increased from less than $200 in 1996 to an average of $429 in 1999. In 2001, the ministry was receiving about 20 tribunal decisions per month and the trend indicated the number of appeals would continue to increase. Also in 2001, BC Person with AIDS Society filed a formal complaint with the Ombudsman concerning the ministry's reliance on the appeal process to provide additional monthly health allowances to persons living with HIV/AIDS.

In October 2001, after significant consultation with a multi-disciplinary advisory group that included health professionals and advocacy groups, Schedule C, s.2 (1) (l) of the Disability Benefits Program regulation was repealed and the Monthly Nutritional Supplement (MNS) was introduced.

MNS provides a monthly monetary supplement to Persons with Disabilities (PWD) clients in receipt of disability assistance who have been confirmed as having a severe medical condition which is causing a chronic, progressive deterioration of health resulting in wasting symptoms. The supplement is intended to prevent an imminent danger to the person's life by providing essential items to alleviate the identified wasting symptoms. MNS is provided in three components:

- nutritional items that are part of a caloric supplementation to regular dietary intake ($165),
- bottled water if suffering moderate to severe immune suppression ($20), and
- vitamins/minerals ($40)

PWD clients may apply for any one or all of the components by having their medical or nurse practitioner complete the Application for MNS form (HSD2847) – See Appendix A.

Recipients of an appeal award for a monthly health allowance are not eligible for MNS. If the amount of their award is less than the amount of MNS, they may apply for the MNS. If approved, the MNS would replace the previously awarded supplement.

In addition, MNS recipients are not eligible for short-term nutritional supplements or the tube feed supplement. By policy, recipients who are only in receipt of the bottled water and/or the vitamins and minerals portion of MNS do retain eligibility for a diet supplement.

DISCUSSION:

Trend Analysis

Not Responsive

Not Responsive

Monthly Nutritional Supplement

When MNS was introduced in 2001, the ministry estimated that about 4,000 clients would be eligible for the supplement. Since 2001, the PWD caseload has gone from about 43,000 to 70,000.

Not Responsive

In the first two fiscal years (2001/02 and 2002/03) after the MNS program was initiated, there were 5,359 distinct clients who received MNS. However, after six to seven years, 3,239 of the 5,359 clients (60 percent) are in receipt of MNS during the last (2008/09) fiscal year. Although MNS was initially designed to provide additional assistance for people with catastrophic illnesses who are near the end of their lives, the data above does not support this view. The majority of MNS recipients are remaining on assistance for many years.

Since 2004/05, the percentage of PWD cases receiving MNS has increased from 9.3 percent to 10.6 percent 2008/09. This shows that the proportion of PWD cases receiving MNS has remained relatively consistent over the last five years. However, as the overall PWD caseload grew 26 percent during these five years, the result has been a significant rise in MNS cases and an increase in expenditures of $3.5 million. The following table shows a breakdown of MNS cases and expenditures for the last five fiscal years:

Table 2: Breakdown of MNS cases and expenditures by fiscal year

Fiscal Year	MNS Allowances	Cases	y/y % Increase	Expenditures
2004/05	Nutritional Items Bottled Water Vitamins/Minerals	4430 2931 4559	+12% +12% +10%	$13.2M
2005/06	Nutritional Items Bottled Water Vitamins/Minerals	4724 3171 4913	+6.6% +8.2% +7.8%	$13.7M
2006/07	Nutritional Items Bottled Water Vitamins/Minerals	4901 3259 5084	+3.8% +2.8% +3.5%	$14.3M
2007/08	Nutritional Items Bottled Water Vitamins/Minerals	5464 3513 5701	+11.5% + 7.8% +12.1%	$15.0M
2008/09	Nutritional Items Bottled Water Vitamins/Minerals	6273 3840 6656	+ 14.8% + 9.3% + 16.8%	$16.7M

In 2008/09, actual program expenditures exceeded budgeted expenditures by $700,000. The program budget for 2009/10 has been increased to $17.5 million and forecasts predict MNS expenditures to reach $21 million by 2011/12. Unless there are significant changes made to the program, the trend indicates there will be continued growth, resulting in ongoing budget pressures and risking the long term sustainability of MNS.

Why the Increase in Costs?

Not Responsive

MNS was introduced to provide a monetary supplement to assist clients facing a catastrophic illness and who require additional nutritional intake to alleviate life threatening wasting symptoms, (i.e.: AIDS, HIV+ and ALS). However, clients with other chronic medical conditions such as diabetes, morbid obesity, osteoporosis, and schizophrenia are also meeting the current eligibility criteria.

Since MNS was introduced there have been significant advances in medicine, such as antiretroviral drugs for HIV and combination antiviral therapy for Hepatitis C, that have resulted in more positive outcomes with regard to prognosis and life expectancy for persons that may have previously been considered terminal.

Over the last five years, fundamental shifts in ministry direction have likely impacted the MNS caseload growth. These changes include:

- Great Goal 3 - In February 2005, the Government of BC committed to building the best system of support in Canada for persons with disabilities.
- Provincial Disability Strategy - The disability strategy involves community, including government, working together to support persons with disabilities. The ministry has looked at meeting individual needs using broad interpretations of regulations.
- Client Centred Service – the goal is to ensure that clients get everything they are eligible for in a timely manner. The ministry has made great strides in setting and maintaining service standards.

MNS Program Review

A review of MNS was completed and the following were identified as areas of concern.

Decision Making Authority for MNS

Under the current regulation, for a person to be eligible to receive MNS, the minister must be satisfied that a medical/nurse practitioner has confirmed that the applicant meets the specified eligibility conditions. This regulatory language places the discretionary authority with the medical/nurse practitioner rather than with the Minister. This is inconsistent with other regulatory language which ensures the ministry is the decision maker. In past discussions with the ministry, the BC Medical Association's stated position is that physicians should not be seen as adjudicators but rather as suppliers of patient information.

MNS Application Form

To apply for MNS, a client must have the Application for MNS form (HSD2847) completed by their medical/nurse practitioner and submitted to Health Assistance Branch (HAB) for adjudication. In the current application form, many of the eligibility questions can be answered by ticking a yes/no box. While specific details to support the response are also requested, once the health professional has responded "yes", the regulatory requirements for approval have been met.

With other application forms, such as the PWD designation application, the ministry has moved to more narrative to ensure evidence based decision making. The yes/no eligibility questions in the MNS application in combination with the current regulatory language restrict the ability for the ministry to exercise discretion when adjudicating the applications. The result has been MNS approvals for clients with medical conditions that did not meet the intent of the supplement and a significant number of cases being approved through reconsideration and appeal.

Reconsideration and Appeals

MNS consistently generates a high number of requests for reconsideration and appeal when compared with other health supplements. The following table shows a breakdown of reconsideration and appeal statistics for the last three fiscal years:

Table 3: Reconsideration and Appeal Statistics 2006/07 to 2008/09

Fiscal year	Reconsideration		Appeal	
	Approved	Denied	Approved	Denied
2006-07	43 (24%)	135 (76%)	26 (55%)	21 (45%)
2007-08	45 (24%)	139 (75%)	10 (35%)	19 (65%)
2008-09	39 (22%)	141 (78%)	10 (59%)	7 (41%)

Over the last three years, 23 percent of HAB denials were subsequently approved at reconsideration. Over this same time period, 50 percent of the cases that were denied at reconsideration and went on to appeal were overturned by the Employment and Assistance Appeal Tribunal.

Review Policy

While diet supplements are subject to regular review to confirm ongoing eligibility, to date, the ministry has never established a review policy and set review dates for MNS.

The general authority for reviews is found in Section 10 of the *Employment Assistance for Persons with Disabilities (EAPWD) Act* and EAPWD regulation section 67(2) provides the ability for the ministry to review the need or continuing need for MNS through the opinion of an alternate medical practitioner.

At the inception of MNS, it was thought that the majority of approvals would not require review as it was believed that the MNS recipient's progressive deterioration of health would be unlikely to improve.

In the absence of a review policy, the ministry continues to provide additional support funds of up to $225 per month to clients who may no longer have a substantiated medical need for supplementation to their regular dietary intake. The regulation was written to allow the ministry to seek a second opinion on questionable cases. However, the regulatory requirement to involve an alternate medical practitioner to confirm the continuing need is both

unnecessary and problematic at a time when access to alternate physicians can be difficult. This aspect of the regulation would need to be amended to enable the development of a review policy for MNS.

Bottled Water

The ministry spent approximately $800,000 for bottled water in fiscal year 2008-09. Bottled water is provided to recipients of MNS who are suffering from moderate to severe immune suppression with the intent to reduce the risk of transmission of water-borne diseases. During the development phase of MNS, the advisory committee was unable to come to consensus on the requirement for or efficacy of bottled water. The conflicting opinions on the benefits of bottled water over tap water continue today. The quality standards for bottled and municipal waters in Canada are similar[2]. Research supports that boiling water is as safe and in some cases safer than bottled water for immuno-compromised individuals, as bottled water is not sterile and there are no mandatory health standards for bottled water. However, the challenge for our clients is that boiling and storing water may not be possible due to a disability or housing situation.

Rates and Delivery of MNS

The MNS rates are set out in regulation - nutritional items ($165), bottled water ($20), and vitamins/minerals ($40) - and applicants may be found eligible for any one or all of the components to a maximum of $225 per month. Items requested under nutritional items must be required in addition to a regular dietary intake and can include food and/or nutritional supplements. These amounts are paid regardless of the actual cost of the recommended items. While it is expected that MNS recipients purchase the required vitamins, food/nutritional items and bottled water with these additional support funds, there is no way of knowing if these funds are used for their intended purpose.

As this is a monetary supplement to their regular support funds, some clients may spend in excess of the maximum amount, while others may not require the full rate to purchase the required items. For instance, a person may only require vitamins that cost $20 per month yet they would receive $40/per month with the approval of MNS. Where in some cases, the additional meat/protein, fruit and vegetable requirements may exceed the $165/per month provided.

Providing product rather than cash would remove the discretionary nature of the supplement. However, there would be a high cost to administering and product stocking such a program and the ministry would not be able to provide the food items that regularly appear on the recommended list of items prescribed by the medical practitioner.

[2] Source: Health Canada – The Safety of Bottled Water

Requests for MNS in the absence of an appropriate diet supplement

The ministry has been approached on numerous occasions by health professionals advocating for changes to the diet supplement. Two such changes include a diet supplement for phenylketonuria (also known as PKU) and a ketogenic diet supplement.

PKU is a rare genetic disorder[3] that results in an enzyme deficiency. People with PKU have a build-up of the enzyme phenylalanine in the blood and other body tissues. If untreated, this can cause severe problems, such as developmental delay, mental deficiency, seizures, and autistic-like behaviour. PKU is treated by eliminating phenylalanine from the diet. As Phenylalanine is present in all protein foods, such as meat, eggs and milk, a special diet low in protein is required. Doctors recommend that the PKU diet be followed for life, as some individuals who have stopped the diet have encountered problems later in life. Similarly, the requirement for a ketogenic diet, a diet high fat with adequate protein and in low carbohydrate, primarily used to treat difficult-to-control (refractory) epilepsy in children[4].

Currently, clients requiring dietary assistance for PKU or ketogenic diets are being denied a diet supplement as they do not meet the eligibility criteria. Anecdotal evidence indicates that in some cases these clients are accessing MNS for additional funding to meet their dietary needs.

Cross Jurisdictional Comparison

There are no identical programs to MNS administered through provincial/territorial social services agencies. BC is unique in providing funds specifically to purchase bottled water, vitamins and dietary items. Most jurisdictions do provide funding through a monthly dietary benefit. Ontario's Special Diet Allowances for medical conditions that result in wasting/weight-loss are the closest to MNS both in terms of criteria and monetary value.

Ontario

Ontario Works has a Special Diet Allowance (SDA), which provides additional assistance to clients who require a special diet as a result of an approved medical condition. There are over 20 different diet supplements with amounts ranging from $10 to $250 per month with the majority requiring annual renewal (See Appendix C). However, Ontario has indicated there are a number of challenges with their current program including increased uptake in recent years, extensive cost pressures and a significant number of SDA related human rights challenges currently under way alleging discrimination due to the exclusion of a medical condition from the SDA schedule.

The SDAs provided for the weight-related medical conditions listed in Appendix C are not subject to review and recipients continue to be eligible for an SDA even when their weight

[3] Incidence of PKU in Canada is 1:15,000 births (est 11 BCEA clients)
http://www.savebabiescanada.org/Resources/Publications/HanleyArticle.pdf
[4] Incidence of Epilepsy in BC for children <19 is 5.5:1000 (incidence of refractory epilepsy varies, 10-40% of 200 BCEA children – 20-80 children)

improves. Ontario measures the severity of these conditions based on the percentage of wasting/weight-loss the applicant is experiencing. If a recipient initially qualifies under one subcategory of weight loss and continues to lose weight they could be eligible under a higher subcategory regardless of whether or not a specified time period has been indicated on the application. A new application form is required to facilitate any changes in a recipient's SDA.

Alberta

Alberta's AISH program provides funds for a special diet. Monthly rates range from $20 for a diabetic, heart healthy diet to $110 for renal failure/insufficiency. The diet for HIV/AIDS, Hepatitis C is $36 per month.

POLICY OPTIONS FOR MNS:

The following options are presented as possible solutions to ensure program sustainability while meeting the needs of clients with extraordinary dietary requirements.

s.13

Option 2: Eligibility Criteria

Option 2a: Amend regulations (recommended)

- ***To ensure that decision making on whether the criteria have been met is with the Minister***

s.13

Option 2b: Amend policy to introduce risk-based reviews on all MNS cases (recommended)

Amend policy and regulation to support a review process to confirm ongoing eligibility for MNS. The review process would examine the existing MNS recipient caseload to identify recipients who are at high risk for ineligibility. These recipients would be asked to provide updated medical information. In addition, all new starts would be given a review date upon approval based on established review criteria.

Option 2c: Amend the application form to use more open ended questions (recommended)

Revise the application form with open-ended questions that will require the medical or nurse practitioner to provide more detailed and substantive information. Form revisions would also include moving the form completion instructions into the body of the application form, an updated applicant declaration and consent and the re-sequencing of questions that will provide a more logical flow in the completion and adjudication of the application.

Implications:

Not Responsive

- Ensures discretionary authority lies with the minister and not with the medical or nurse practitioner.
- Aligns regulatory language and review requirement with other EAPWD and health supplement regulations.
- Provides the ability to reassess recipients who may not require MNS on a permanent basis.
- Supports the ministry's adjudication process through the provision of better quality information to ensure clients who meet the criteria for MNS continue to receive it.
- Decrease in the number of cases being approved that are outside of the intended target group for MNS.
- Expected reduction in the number of cases that require follow up with health professionals during the adjudication process.
- Regulatory changes would be supported by the BC Medical Association.
- Advocates and the Ombudsman's Office may perceive the introduction of a review policy as contrary to previous commitments made by the ministry to reduce medical documentation requirements for clients with chronic medical conditions.

- MNS reviews will increase the work load for HAB for the short term but this impact should be reduced over time as MNS caseload declines.
- Health professionals may want an increase in the $25 fee paid for the completion of the revised application form.

Option 3 s.13

s.13

Option 4: Strengthen Eligibility Criteria

Amend the EAPWD regulation to strengthen eligibility criteria (recommended)

Proposed regulatory amendments to strengthen eligibility criteria would include changes to the list of wasting symptoms that must be displayed to in order to be approved for MNS (for example, the addition of qualifiers to further define each wasting symptom and the requirement to display two or more of these symptoms).

Implications:

Not Responsive

- Supports policy intent and sustainability to ensure supplement is available to those for which it is intended
- Applicants who are at a critical or end stage in the course of their disease will still meet the eligibility criteria
- Detailed descriptors would provide clarity to medical practitioners thereby reduces the number of cases that require follow during the adjudication process.
- Decrease in the number of cases being approved that are outside of the intended target group for MNS.
- Option 4 could be combined with Option 2
- Could be seen as the ministry taking a necessary benefit away from vulnerable clients who do not meet the more stringent criteria.

Option 5: Bottled Water

s.13

Option 5b: Eliminate bottled water (all cases) [recommended]

Implications:

Not Responsive

- Raises a potential health risk for moderate to severe immune-suppressed clients who are unable to access a safe water supply (i.e. those who are not physically able or have access to facilities to boil and store water).
- Could be seen as the ministry taking a necessary benefit away from vulnerable clients resulting in a negative reaction from HIV/AIDS advocacy groups who lobbied for bottled water to be included during the development of MNS.

- Supports the environmental concerns regarding the use of disposable containers.

Option 6 s.13

s.13

s.13

s.13

Not Responsive

- Not Responsive

RECOMMENDATIONS:

Monthly Nutritional Supplement:

Option 2a: Amend policy to introduce risk-based reviews on all MNS cases

Option 2b: Amend regulations

- ***To ensure that decision making on whether the criteria have been met is with the Minister***
- s.13

Option 2c: Amend the application form to use more open ended questions

Option 4: Amend the EAPWD regulation to strengthen eligibility criteria

Option 5b: Eliminate bottled water (all cases)

Not Responsive

Not Responsive

Enclosures/Attachments
Appendix A - Application for Monthly Nutritional Supplement (HSD2847)
Appendix B - Ontario Special Diets Schedule - January 2009
Appendix C - Options Costing Breakdown

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

Approved/Not Approved

Date

Sept 23/09

Robert Bruce
Executive Director

PREPARED BY	REVIEWED BY :	INITIAL	DATE
Pam Christenson Senior Policy Advisor 250-356-8943	Dana Jensen Manager SPRB	IF for	2009/Sep/22
	Alison Bath Director SPRB	AB	2009/Sep/11
	Debbie Moreland Executive Director PSB	Signed via email	

Cliff# 153790
Version #
Updated:

NOTE TO EMPLOYMENT AND ASSISTANCE WORKERS

The Monthly Nutritional Supplement is only available to persons designated as a Person with Disabilities under the *Employment and Assistance for Persons with Disabilities Act (EAPWD),* and who are in receipt of disability assistance.

Before providing this form to a client, please ensure that:

- The applicant has been designated as, and is a person with disabilities and is in receipt of a disability allowance;
- The applicant is not receiving a monthly supplement under Employment and Assistance for Persons with Disabilities Regulation Section 2 (3) of Schedule C, otherwise referred to as the Grand-parented clause.)

An applicant in receipt of monthly supplement with a total value of less than $225 per month has the option of applying for the Monthly Nutritional Supplement which would replace the currently received supplement or supplements.

Please complete Part A of the application form, including **both** the GA file number and the HS file number, and sign the form prior to giving it to the applicant for their information.

When the application is returned to the Employment and Benefits Centre, please ensure all parts of the form are complete. Once completed, forward the original with accompanying documentation to Health Assistance Branch for adjudication. Health Assistance Branch will advise as to the decision and eligibility for each component of the supplement applied for.

Instructions to Medical Practitioners and Nurse Practitioners
- Monthly Nutritional Supplement (MNS) -

Intent:

The purpose of the monthly nutritional supplement is to provide additional financial support to meet the extraordinary nutritional needs of specified Persons with Disabilities recipients. Eligibility for the MNS is defined in the *Employment and Assistance for Persons with Disabilities Act* and Regulation and states that a person must meet the following criteria:

- Have a severe chronic progressive deterioration of health;
- Have a severe medical condition which is the cause of that deterioration;
- Display evidence of specific wasting symptoms;
- Have a need for specified additional items to alleviate these symptoms that, left untreated, would pose an imminent danger to life; and
- Have no other financial resources to meet this need.

The information requested in the attached application is for the purpose of assessing an applicant's eligibility based on these criteria.

The following information is provided to assist medical practitioner or nurse practitioner in completing this form. The information you provide is vital in assessing the needs of the applicants. It is essential that you provide specific information regarding the medical condition and what items are needed. **Incomplete applications cannot be adjudicated and may be returned for more information.**

Question 1: Condition

For our purpose, examples of severe medical conditions which result in a chronic progressive deterioration of health with wasting symptoms would include conditions such as AIDS, Hepatitis C, Cancer and ALS.

Question 2: Height and Weight

Height and weight will assist the adjudicators in determining your patient's Body Mass Index (BMI) which is a relevant indicator of certain wasting symptoms.

Question 3: Symptoms

The regulations outline these as specific symptoms of wasting. However, evidence of one symptom is not necessarily determinative of eligibility for the MNS. For example, patients who are overweight may have weight change but, in the absence of other information as to their medical condition and other symptoms, may not be considered "wasting".

Question 4: Nutritionists' Involvement

This question is for information purposes only. While recipients requiring MNS are encouraged to have a nutritional treatment plan, it is not a requirement of eligibility.

Question 5: Nutritional items ($165 per month)

To be eligible for these items, the medical practitioner or nurse practitioner must confirm that the specific nutritional items are required to alleviate the symptoms of wasting. The need for the items must be **in addition to a normal dietary intake.** Conditions requiring an increase in caloric requirements through **additional** food and/or food supplements would meet the eligibility criteria. Low cholesterol diets, weight reducing diets, and vegetarian diets **do not** meet the intent of the MNS benefit.

Instructions to Medical Practitioners and Nurse Practitioners
- Monthly Nutritional Supplement (MNS) -

Question 5: Nutritional items ($165 per month) (continued)

Vitamin and mineral requirements should not be listed in this section, but in the section specific to vitamins and minerals.

Note: Persons with poor nutrition caused by spending support funds on items other than food, inadequate cooking facilities, or lack of knowledge, inclination, or ability to purchase and cook appropriately will not be eligible for additional nutritional items through the MNS.

Tube feeding and enteral nutrition diets would not be considered for the MNS, as other forms of assistance are available to assist with these situations. Short-term needs for supplements such as Boost or Ensure can also be met through other forms of Ministry assistance.

Diet allowances of up to $40 per month are available and may be sufficient in some cases to provide for the required items.

For further information on eligibility criteria for the diet allowance, and other forms of assistance, patients should contact their Employment and Assistance Worker.

Question 6: Bottled Water ($20 per month)

Where an applicant has immune suppression deficiencies, bottled water may be considered, to prevent the transmission of water borne infections.

Question 7: Vitamins or Mineral Supplementation ($40 per month)

To be eligible for this item, vitamins and minerals are required in dosages above normal amounts, specifically to alleviate the symptoms of wasting. The higher rate of disability assistance received by clients designated as a Person with Disabilities is expected to provide for low cost or occasional use items such as once-a-day multi-vitamins.

Question 5-7 Imminent Danger to Life:

For the purpose of this application, the requirement to prevent "imminent danger to life" is satisfied if the medical condition is at a stage where nutritional intervention is required to relieve the wasting symptoms, to prevent further deterioration or to reduce the rate of further deterioration.

Payment:

The $25.00 fee for completing Part B of this form may be billed through MSP on Fee Item 96400

If you have any questions, please contact:

Health Assistance Branch at 1- 888-221-7711

BRITISH COLUMBIA
The Best Place on Earth

Ministry of Housing and Social Development

APPLICATION FOR MONTHLY NUTRITIONAL SUPPLEMENT

The personal information requested on this form will be used for the purpose of determining eligibility for a monthly nutritional supplement and is protected under the *Freedom of Information and Protection of Privacy Act*. The collection of this information is authorized by the *Employment and Assistance for Persons with Disabilities Act* and Regulation. Any questions about the collection, use or disclosure of the requested medical information should be directed to your local Employment and Assistance Centre.

NOTE: An applicant for the monthly nutritional supplement must be a recipient of disability assistance under the *Employment and Assistance for Persons with Disabilities Act* and Regulation. The Ministry has the discretion to review eligibility for the monthly nutritional supplement. The Ministry may also, where necessary, request a second opinion for the purpose of determining eligibility for this supplement.

PART A - Must be completed by Ministry of Housing and Social Development (Please print)

Applicant Name	Birthdate (YYYY MMM DD)	File No. GA	Personal Health Number (Care Card #)
Applicant Address	Postal Code	HS File No. HS	Telephone

Employment and Assistance Worker & Caseload Number	Date (YYYY MMM DD)

DECLARATION AND CONSENT

I understand that the Ministry of Housing and Social Development may verify and obtain information to confirm my eligibility. I authorize the medical practitioner or nurse practitioner identified in Part B of this application to share the requested medical information with the Ministry of Housing and Social Development.

Applicant Signature	Date (YYYY MMM DD)

PART B - To be completed by the medical practitioner or nurse practitioner (Please print and attach additional sheets if necessary)

NOTE: Eligibility for this supplement is based on strict criteria outlined in the *Employment and Assistance for Persons with Disabilities Act* Regulation related to alleviating specific symptoms AND preventing imminent danger to life. It is NOT based solely on a persons medical condition. Detailed medical information will assist the Ministry in determining eligibility and will reduce the need for further follow-up.

1. Does the applicant have a chronic, progressive deterioration of health due to a severe medical condition? Yes ☐ No ☐

   If yes, please provide specifics of the medical condition and the ensuing deterioration.

   _____

   _____

2. Please specify the applicant's height _____ and weight _____.

3. Does the applicant have any of the following symptoms and if so, are they the direct result of the chronic progressive deterioration of health above?:

   Malnutrition ☐ Please describe: _____

   Underweight status ☐ Please describe: _____

   Significant weight change ☐ Please describe: _____

   Muscle mass loss ☐ Please describe: _____

   Bone density loss ☐ Please describe: _____

   Neurological degeneration ☐ Please describe: _____

   Significant deterioration of an organ ☐ Please describe: _____

   Moderate to severe immune suppression ☐ Please describe: _____

   _____

   _____

4. Is a nutritionist involved in the applicant's treatment plan? Yes ☐ No ☐

5. **NUTRITIONAL ITEMS**:
Does the applicant require these to alleviate any of the above symptoms? (note: must be **in addition to** normal dietary intake) Yes ☐ No ☐
To prevent imminent danger to life? Yes ☐ No ☐
Please specify the additional items required and how they will alleviate the specific symptoms. _____

6. **BOTTLED WATER:**
Will the applicant's risks associated with immune suppression be mitigated by bottled water? Yes ☐ No ☐
Will it prevent imminent danger to life? Yes ☐ No ☐
Please specify how. _____

7. **VITAMIN OR MINERAL SUPPLEMENTATION:**
Does the applicant require these to alleviate any of the above symptoms? Yes ☐ No ☐
To prevent imminent danger to life? Yes ☐ No ☐
Please specify the additional items required and how they will alleviate the specific symptoms.

Additional Comments

Medical Practitioner or Nurse Practitioner Name	Medical Practitioner or Nurse Practitioner Number	Telephone
		( )
Medical Practitioner or Nurse Practitioner Signature		**Date (YYYY MMM DD)**

PART C - To be completed by the Ministry of Housing and Social Development

Applicant is eligible for:

(a)	Monthly supplement for additional nutritional items	Yes ☐	No ☐
(b)	Monthly supplement for bottled water	Yes ☐	No ☐
(c)	Monthly supplement for vitamins and minerals	Yes ☐	No ☐

Additional Comments

Adjudicator Signature	Date (YYYY MMM DD)

Pages 135 through 136 redacted for the following reasons:
- -
Not responsive

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

DATE: December 21, 2009

PREPARED FOR: Rob Bruce, Executive Director

ISSUE: Amendments to Monthly Nutritional Supplement and Not Responsive

BACKGROUND:

The Monthly Nutritional Supplement (MNS), introduced in October 2001, is a monthly monetary supplement which may be provided to Persons with Disabilities (PWD) clients in receipt of disability assistance. The client must be confirmed as having a severe medical condition which is causing a chronic, progressive deterioration of health resulting in wasting symptoms. The supplement is intended to prevent an imminent danger to the person's life by providing essential items to alleviate the identified wasting symptoms.

MNS is provided in three components: nutritional items part of a caloric supplementation to regular dietary intake ($165), bottled water if suffering moderate to severe immune suppression ($20), and vitamins/minerals ($40). PWD clients may apply for any one or all of the components by having a medical or nurse practitioner complete an MNS application form. Health Assistance Branch (HAB) adjudicates these forms.

Not Responsive

DISCUSSION:

MNS expenditures have grown significantly over the past five years, risking the long-term sustainability of the supplement. In 2004/05, expenditures totaled $13.2 million. In 2008/09, expenditures topped $16.7 million, an increase of 27 percent. While the proportion of PWD cases receiving MNS has remained relatively consistent over the last five years, the overall PWD caseload grew 26 percent resulting in a significant rise in MNS cases. Although MNS was initially designed to provide additional assistance for people with catastrophic illnesses who were near the end of their lives, caseload data has shown the majority of MNS recipients are remaining on assistance for many years. In addition, shifts in ministry direction over the past five years have also likely impacted the MNS caseload growth. These changes include Great Goal 3, the provincial disability strategy, and client centred service delivery.

The Employment & Income Assistance Branch (EIAB) has worked in consultation with Provincial Services Branch and Regional Services Division to review MNS. A detailed analysis of the sustainability of MNS was prepared. It was concluded that the provision of MNS had expanded beyond the original policy intent resulting in clients with chronic but manageable medical conditions meeting the current eligibility criteria. Unless significant changes are made to the supplement, the

number of cases will continue to grow resulting in ongoing budget pressures. A variety of approaches were researched and presented to executive (see Appendix A – Presentation to Deputy Minister) resulting in the following options.

OPTIONS:

Not Responsive, s.13

Option 2: Amend MNS regulation, policy, and procedures to ensure program sustainability while meeting the needs of clients with extraordinary dietary requirements. (RECOMMENDED)

- Amend regulations to ensure MNS eligibility is determined by the Minister.
- Amend regulations to strengthen eligibility criteria related to the wasting symptoms.
- Implement a risk-based review process to reassess recipients who may not require MNS on a permanent basis.
- Eliminate bottled water for all cases with a three month transition period for current cases.
- Amend the regulations to support the option of a care in lieu of cash delivery model.

Implications:

- Not Responsive
- MIS systems changes required. Cost estimate: $28,080 – $42,120.
- Changes to the application form will be required to better support an evidence-based adjudication process and ensure clients who meet the criteria for MNS continue to receive it.
- Introduction of a review process and changes to the eligibility criteria will decrease the number of cases being approved that are outside of the intent of MNS.
- Supporting a flexible delivery model that includes a care in lieu of cash option ensures that supplementary assistance will be used for the intended purpose.
- MNS reviews will increase the work load for HAB for the short term but this impact should be reduced over time as MNS caseload declines.
- Elimination of bottled water raises a potential health risk for moderate to severe immune-suppressed clients who are unable to access a safe water supply.
- Health Canada indicates people who wish to take extra precautions can boil their water for one minute to kill any parasites that may be present.
- Advocates and the Ombudsperson may perceive a review policy contrary to previous ministry commitments to reduce medical documentation requirements.
- Overall changes may be seen as the ministry taking necessary benefits away from vulnerable clients resulting in a negative reaction from advocacy groups and clients.

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

Not Responsive

RECOMMENDATIONS:
Option 2: Amend MNS regulation, policy, and procedures to ensure program sustainability while meeting the needs of clients with extraordinary dietary requirements
and

Not Responsive

Consultation:
Raymond Fieltsch, Director, Regional Services Division

ENCLOSURES:
Appendix A – Presentation to Deputy Minister

Approved/Not Approved	Date
Orig signed by RB Rob Bruce Executive Director	March 2, 2010

PREPARED BY:	REVIEWED BY:	INITIAL:	DATE:
Pam Christenson Senior Policy Advisor 250-387-4008	Dana Jensen Manager, EIAB	Orig signed by DJ	March 2010
	Alison Bath Director, EIAB	Orig signed by AB	March 2010

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

Appendix B - Ontario Special Diets Schedule - January 2009

COLUMN A MEDICAL CONDITION that requires a Special Diet	COLUMN B Monthly Amount for Special Diet Unless Otherwise Specified
Wasting/weight-loss due to one or more of the following medical conditions: • Amyotrophic Lateral Sclerosis • Crohn's Disease • HIV/AIDS • Lupus • Malignancy • Multiple Sclerosis • Ostomies [e.g., jejunostomy, ileostomy] • Pancreatic Insufficiency • Short Bowel Syndrome • Ulcerative Colitis	
wasting/weight-loss ≤ 2% of usual body weight	$75
wasting/weight-loss of > 2% and ≤ 5% of usual body weight	$150
wasting/weight-loss of > 5% and ≤ 10% of usual body weight	$180
wasting/weight-loss of > 10% of usual body weight	$240
Wasting/weight-loss due to one or more of the following medical conditions: • Anorexia Nervosa • Cystic Fibrosis • Kwashiorkor • Marasmus	
weight loss ≤ 2% of usual body weight	$75
weight loss > 2% of usual body weight	$150
Cardiovascular Disease	$10
Celiac Disease	
Less than 2 years of age	$58
2-10 years of age	$115
11-18 years of age	$147
19 years of age or older	$131
Chronic Constipation	$10
Chronic wounds requiring protein	$10
Congenital Abnormalities of the Metabolic Type – Adults	$10
Congenital Abnormalities of the Metabolic Type – Infants & Children	$10
Congestive Heart Failure	$44
Diabetes	$42
Diverticulum / Diverticulitis	$10
Dysphagia/Swallowing or Mastication Difficulties	$25 AND $75 one-time amount for the cost of a blender, if funding for a blender has not been previously provided

COLUMN A MEDICAL CONDITION that requires a Special Diet	COLUMN B Monthly Amount for Special Diet Unless Otherwise Specified
Extreme Obesity: Class III BMI > 40	$20
Food Allergy – Eggs	$10
Food Allergy - Milk/Dairy or Lactose Intolerance Less than 2 years of age 2-10 years of age 11-18 years of age 19 years of age or older	 $95 $97 $55 $35
Food Allergy – Soya	$83
Food Allergy – Wheat Less than 2 years of age 2-10 years of age 11-18 years of age 19 years of age or older	 $38 $77 $98 $57
Gestational Diabetes *[Diet is available during pregnancy and for 3 months post partum]*	$44
Gout	$32
Hyperlipidemia	$10
Hypertension	$10
Hypertension and Congestive Heart Failure and Grade 1 to 2 left ventricular function	$44
Hypercholesterolemia	$22
Inadequate lactation to sustain breast-feeding or breast-feeding is contraindicated during the first 12 months of infant's life lactose tolerant lactose intolerant *A Special Diet Allowance will be paid during the first 12 months of an infant's life, if formula is necessary due to inadequate quantity of breast milk or if breastfeeding is contraindicated [e.g. infant is unable to tolerate breast milk; mother's milk is contaminated due to other conditions or medical treatments such as HIV/AIDS, chemotherapy; infant has galactosemia].*	 $75 $83
Liver Failure/ Hepatic Disorders	$10
Macrocytic Anaemia	$10
Malabsorption	$20
Microcytic Anaemia	$30
Osteoporosis/ Osteomalacia/ Osteopenia	$10
Post-gastric surgery	$10
Prediabetes: Impaired Glucose Tolerance (IGT) or Impaired Fasting Glucose (IFG)	$42
Renal Failure- Dialysis	$44
Renal Failure- Pre-Dialysis	$44

Ministry of Housing and Social Development

Appendix A

Supplements Review Presentation to the Deputy

October 2009

BRITISH COLUMBIA

The Best Place on Earth

Monthly Nutritional Supplement – Current Policy

The **Monthly Nutritional Supplement (MNS)** provides a monthly monetary supplement to PWD clients with a severe medical condition which is causing a chronic, progressive deterioration of health resulting in wasting symptoms.

The supplement is intended to prevent an imminent danger to the person's life by providing essential items to alleviate the identified wasting symptoms. MNS is provided in three components:

- **nutritional items** that are part of a caloric supplementation to regular dietary intake **($165)**,
- **bottled water** if suffering moderate to severe immune suppression **($20)**, and
- **vitamins/minerals ($40)**

Monthly Nutritional Supplement – History
The Precursor to MNS

1996 - 2001 Requests received for **monthly health allowances** for Disability Benefits recipients living with HIV/AIDS to assist with additional costs associated with their illness. After being denied, recipients successfully appealed the denials to the BC Benefits Tribunal

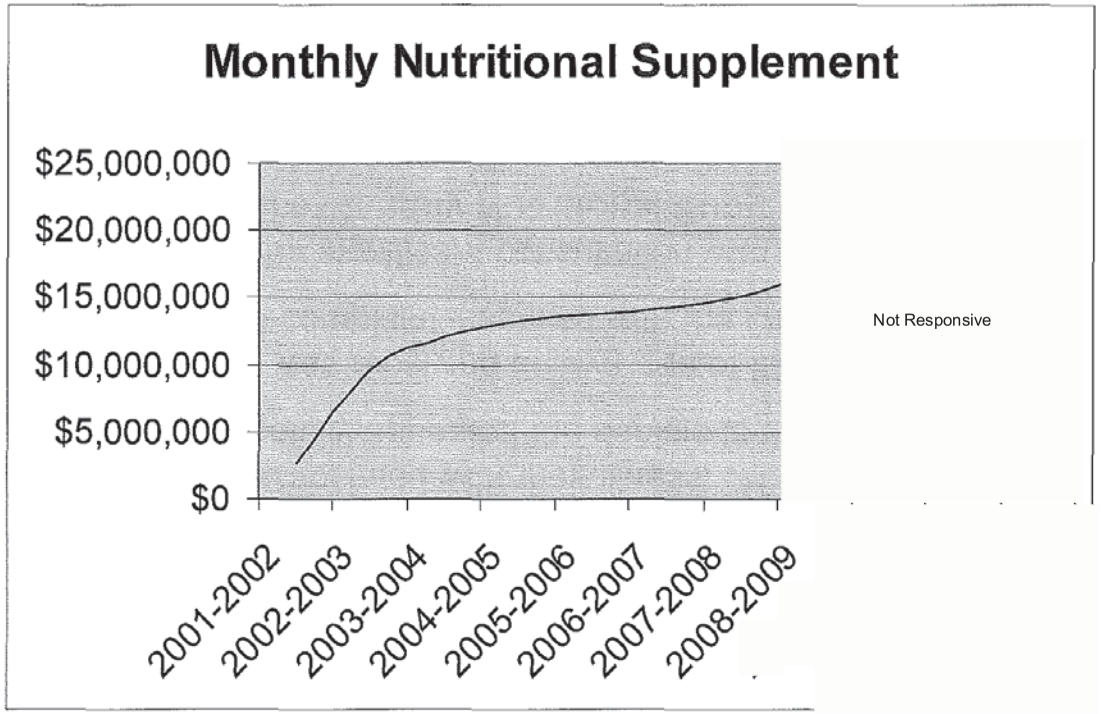
By 2001 Ministry was receiving an average of **20 tribunal decisions per month** and a complaint was filed with the Office of the Ombudsman

October 2001 After significant consultation with a multi-disciplinary advisory group, the **Monthly Nutritional Supplement** was introduced

No major policy changes have occurred since the inception of MNS

MNS is a program unique to BC - Ontario's SDAs for wasting/weight loss are the closest to MNS both in terms or criteria and monetary value

Monthly Nutritional Supplement – Budget & Expenditures



Monthly Nutritional Supplement – Issues

- Current regulatory language
  - discretionary authority with medical practitioner
  - eligibility criteria too broad
- Application form does not support discretionary decision making
- Absence of review policy
- Conflicting opinions on benefits of bottled water
- Provided as cash not product
- Requests for MNS instead off or in the absence of appropriate diet supplement
- Expenditures are steadily increasing

Monthly Nutritional Supplement – Recommended Options

Amend MNS regulations, policy and procedures to support sustainability

- Ensure that decision making on whether the criteria have been met is with the minister
- Strengthen eligibility criteria (wasting symptoms)
- Support review policy
- s.13
- Amend the application form to use more open ended questions

- Aligns regulatory language with other EAPWD and health supplements
- Decreases the # of cases being approved that are outside the intent of MNS
- Application changes support the adjudication process – better quality information!
- Ombudsman and Advocates may perceive a review policy as contrary to previous ministry commitments to reduce medical documentation requirements

Monthly Nutritional Supplement – Recommended Options, cont'd

Eliminate bottled water – ALL cases

- Health Canada indicates that boiling tap water is an alternative approach as bottled water is not routinely monitored for parasites
- Potential health risk for moderate to severe immune suppressed clients due to lack of facilities and physical ability to boil water/store water
- Could be perceived as a rate cut ($20/month)
- Requires transition plan for clients currently receiving supplement

- Not Responsive

Estimated systems costs: 28,000 - $42,000

Not Responsive

Monthly Nutritional Supplement – Options Not Recommended

s.13

Monthly Nutritional Supplement – Options Not Recommended

s.13

Monthly Nutritional Supplement – DM Decision Summary

1. **Amend regulation to:**
   - Ensure that decision making authority is with the minister
   - Strengthen eligibility criteria related to wasting symptoms
   - Provide "up to" the maximum supplement amount to allow the ministry flexibility in how the supplement can be delivered (e.g., in-kind versus cash)
2. **Eliminate bottled water**
   - all cases with 3 month transition period for current cases
3. **Implement a risk-based review process to confirm ongoing eligibility**
4. **Amend the application form to better support evidence-based decision making**

Not Responsive

Monthly Nutritional Supplement (MNS)

Issues Identified:

- Eligibility criteria too broad – allows approvals outside the intended target group
- No conclusive evidence that bottled water is superior to drinking water available in BC
- Since supplement introduced, significant improvements in health care, increasing life expectancy and quality of life – person may no longer be in need of supplement
- Caseload growth significantly exceeded the growth of the PWD caseload. Further analysis revealed that supplement was being received in situations that did not meet the original intent of the program

Previous Policy	Changes made April 2010	Rationale
• PWD clients with a severe medical condition causing a chronic, progressive deterioration of health resulting in wasting symptoms. • Intended to prevent an imminent danger to the person's life by providing essential items to alleviate the wasting symptoms. • Person must display <u>one</u> or more of the following symptoms: ❖ malnutrition ❖ underweight status ❖ significant weight change ❖ muscle mass loss ❖ bone density loss ❖ neurological degeneration ❖ significant deterioration of an organ ❖ moderate to severe immune suppression • Monthly cash supplement in three parts: ❖ **nutritional items** that are part of a caloric supplementation to regular dietary intake **($165)**, ❖ **vitamins/minerals ($40);** and ❖ **bottled water** if suffering moderate to severe immune suppression **($20)**	**Eligibility criteria tightened** • Wasting symptoms redefined and person must display <u>two</u> or more: ❖ malnutrition ❖ underweight status ❖ significant weight <u>loss</u> ***(used to be significant weight change)*** ❖ <u>significant</u> muscle mass loss ❖ <u>significant</u> neurological degeneration ❖ significant deterioration of an <u>vital</u> organ ❖ moderate to severe immune suppression • The symptom of **bone density loss** was removed	• Ensures that MNS is available to people with the greatest health need and most at risk ❖ HIV/AIDS, ALS, Crohn's Disease ❖ Cancer and Other end-stage diseases • Review of file showed more than 95% had 2 or more symptoms • Clarifies what was meant by weight change and ensures supplement is available to intended target group (unintended weight loss resulting in wasting) • Introducing "significant" test ensures supplement is intended to assist PWD clients with "severe" conditions • Introduction of "vital" organ, prevents persons with disease/injury to organ that does not require a special diet (e.g., damaged eye) <u>Client Impact</u>: ❖ persons with weight gain or persons with obesity who have weight loss, but not considered "wasting"; ❖ clients who have a medical condition, but are not showing signs of wasting; ❖ persons with only one symptom; program not intended to assist persons who do not have a severe medical condition • Removing "bone density loss" ensures supplement meets intended policy to provide for persons with severe medical conditions and signs of wasting <u>Client Impact</u>: ❖ persons diagnosed with Osteoporosis only as diagnosis, however, needs can be met through $40 Diet Supplement

	Bottled water has been eliminated • Existing clients had a 3 month transition period • Reduction occurred on July 2010 benefit month (cheque issued June 23rd, 2010)	• BC has amongst the best potable water systems. • Substantial health and environmental benefits from consuming municipal drinking water rather than bottled water. Municipal drinking water, unlike bottled water, is monitored and disinfected. • Ministry has ability to assist impacted clients who require assistance to meet an unexpected need through a crisis supplement. ❖ A client impacted by a boil water advisory or other emergent situation that results in an unsafe water supply, could be issued a crisis supplement for the purchase of a kettle. Client Impact: ❖ Approx 3700 clients received the $20 supplement ❖ Notification sent to clients April 2010
	Eligibility review • Policy guidelines introduced that will be used by staff to confirm ongoing eligibility for MNS ❖ Review existing medical information already on file. During this first stage, ministry will consider various factors including, but not limited to, the nature of the medical condition, likelihood of improvement and/or recovery and the duration of need indicated by the health professional. ❖ In cases where the medical documentation on file confirms ongoing eligibility, there will be no change to the client's file and they will continue to receive MNS. ❖ If insufficient information to confirm ongoing eligibility, recipients will be notified that a new MNS application form must be submitted. ❖ Upon receipt of the new MNS application, the ministry will make an eligibility decision and advise the client of the outcome.	• As medical conditions can change, the ministry retained the ability to review ongoing eligibility for the Monthly Nutritional Supplement and introduced policy guidelines to be used by staff when reviewing individual cases. • Reviewing ongoing eligibility ensures that only those that continue to be in need receive the supplement Client Impact: Minimal ❖ only those clients who no longer are in need of the supplement (e.g., someone who has been in remission for 10 years) • Review process is the same as for other ministry programs such as PWD designation, diet supplement • While the ministry contemplated a review of the existing MNS caseload to confirm ongoing eligibility, a full-scale review will not be completed at this time.

	New Application Form • Redesigned to accommodate changes	• Supports policy intent and allows for collection of more detailed information • Purpose and criteria indicated on the form which provides necessary clarity to assist physicians when assessing needs • Reduces need for follow-up with physicians • Supports equitable decisions and avoids unnecessary reconsiderations and appeals • If comprehensive information is o0btained during initial application, need for future reviews is minimized
Cross Jurisdictional		
Alberta	Does not have a similar or equivalent benefit	
Ontario	Ontario provides a Special Diet Allowance (SDA) for unintended weight loss/body wasting due to one or more of these medical conditions: o Amyotrophic Lateral Sclerosis o Anorexia Nervosa o Crohn's Disease o Cirrhosis o Congestive Heart Failure o Cystic Fibrosis o HIV/AIDS o Lupus o Malignancy o Multiple Sclerosis o Ostomies [e.g., jejunostomy, ileostomy] o Pancreatic Insufficiency o Short Bowel Syndrome o Ulcerative Colitis • Lost between 5% and 10% of usual body weight $191 • Lost more than 10% of usual body weight $242 **Note:** Effective April 1, 2011, changes were made to the SDA to make the program more accountable and comply with a Human Rights Tribunal of Ontario decision. Changes included: • Revising the list of eligible medical conditions. Allowances for some medical conditions have increased, others have decreased. Also, medical conditions that the Special Diets Expert Review Committee found to not require a special diet that involves additional costs were removed. This means some people will stop getting an allowance at the end of the transition period, July 31/11. • Requiring recipients to consent to the release of relevant medical information to support their application, and • Putting stronger tracking methods in place to improve accountability. The changes to the SDA were based on recommendations made by the Special Diets Expert Review Committee. These recommendations are continuing to be challenged at the Human Rights Tribunal and the Social Benefits Tribunal.	

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

DATE: December 15, 2009

PREPARED FOR: Rob Bruce, Executive Director

ISSUE: Life Threatening Health Need Policy

BACKGROUND:
Life Threatening Health Need (LTHN) is intended to provide a specific health supplement for any resident of BC who faces a threat to their life and has no other resources. Access to health supplements through the LTHN is available to clients that would otherwise not have access to health supplements, as well as non-clients who demonstrate a need for a specific supplement.

Currently, Section 76 of the Employment and Assistance Regulation allows a person with a LTHN access to any Schedule C supplement, which includes: medical equipment and supplies, dental, optical, extended medical therapies, medical transportation, infant and natal supplements, should they meet the eligibility criteria for the requested supplement.

The Employment and Income Assistance Branch (EIAB) has identified a number of issues and is proposing a suite of amendments to the LTHN policy. The changes are intended to ensure that health supplements obtained through this avenue meet their intent. In October 2009, EIAB completed a comprehensive review of health supplements and obtained approval in principle for amendments that would ensure that health supplements were provided to those who are most in need (Appendix A – DM Presentation – LTHN)

DISCUSSION:
Interpretation of 'life-threatening'
The ministry does not have a definition of 'life-threatening', which makes it difficult for staff to assess LTHN eligibility. The lack of a clear definition has resulted in a broad interpretation of LTHN being used by staff and the appeals tribunal. To ensure that health supplements are issued in only the most extreme situations, where an immediate need to deal with a LTHN to prevent serious injury or death has been identified, the Ministry requires a description of "life-threatening" and will be amending regulation to include references to "a direct and imminent" life threatening health need. MHSD should also outline policy guidelines for what situations are considered when determining if a person has a LTHN.

Discrepancies between LTHN Policy, Regulation and Regional Practice
Regulation for LTHN states that the ministry may provide any health supplement set out in Schedule C, if the applicant meets the criteria of the specific supplement. This regulation has remained the same since its inception in the 1970's, when Schedule C originally consisted of medical supplies and equipment only, supplements that would be considered to meet the intent of a LTHN. As new health supplement programs were developed (e.g., dental and optical), regulatory authority for the supplement was placed under Schedule C. Although LTHN policy was amended, the LTHN regulation was not aligned. In the case of the diet supplement and monthly nutritional supplement (MNS), the criteria were written

outside of Schedule C while the rates were written into Schedule C. Legal opinions have indicated that the ministry may be bound to provide these supplements under LTHN as the rates are written into Schedule C.

MHSD should amend regulation to specify that medical equipment, medical supplies and medical transportation are the supplements available under LTHN, should the applicant meet the eligibility criteria for a specific supplement. This amendment will realign policy intent and regulation and ensure that the supplements that are issued are integral to the survival of the recipient. Aligning policy and regulation will also enable staff to clearly assess eligible health supplements under LTHN.

Income Testing
Unlike clients applying for supplements through income or disability assistance, citizens are able to access health supplements through LTHN without meeting specific income and asset tests. Citizens are required to fill out a Health Needs Request Form (0435) in order to assess their financial eligibility for health supplements through LTHN. The form requires applicants to document income and expenses, but does not have a specific financial threshold that would trigger ineligibility. Implementing income testing for LTHN would address inequities between low income citizens who independently pay for health supplements and those who access them through LTHN. Families receiving any level premium assistance are eligible for additional health care services through MHSD's Healthy Kids program. Tying LTHN to the thresholds for MSP Premium Assistance allows MHSD to have income testing while linking the eligibility criteria for three health-related government programs and eliminates the need for the Health Needs Request Form.

Systems
LTHN cases tracked using the same code as Medical Services Only (MSO) in the Ministry Information System (MIS). MSO clients are eligible for MSP Premium Assistance and Pharmacare. As a result of LTHN being coded in MIS as 08 with MSO cases, persons approved for supplements under LTHN are also inadvertently being approved for MSP Premium Assistance and Pharmacare. Amendments to MIS should be pursued in order to properly track and report on LTHN and minimize errors. The estimated costs of the changes are between $40k and $60K.

Implementation Impacts
- MHSD will need to conduct a review of code 08 clients to identify LTHN clients
- Existing clients with an approved ongoing LTHN will be unaffected until that need is due for renewal

OPTIONS:

s.13

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

OPTION 2: Amend LTHN regulation to add reference of "direct and imminent", implement income testing based on MSP Premium Assistance, and limit eligible items to medical supplies, medical equipment and medical transportation: s.13

Implications:

- Provides only necessary health supplements to those who demonstrate a direct and imminent threat to their life and resolves discrepancy between regulations and policy
- MNS and diet rates will still be in Schedule C which leaves the ministry open to reconsideration and appeals
- Systems costs from $43,200 to $64,800
- Ability to accurately report out on MSO and LTHN caseload numbers
- Increased RSD workload (one time code 08 review)
- Community advocacy groups likely to oppose changes and community organizations which assist people with meeting their health needs may see increase in requests
- Income testing creates a more equitable program based on financial need

RECOMMENDATION:

OPTION 2: Amend LTHN regulation to add reference of "direct and imminent", implement income testing based on MSP Premium Assistance, and limit eligible items to medical supplies, medical equipment and medical transportation: s.13

Enclosures/Attachments

- Appendix A – DM Presentation - LTHN

Approved/Not Approved Date:

Mar 4/10

Rob Bruce
Executive Director

PREPARED BY:

Krishna Mann
Policy Analyst
250.356.6907

REVIEWED BY (pls initial): DATE:

Dana Jensen DJ Feb 25/10
Manager, Employment and Income Assistance Branch

Alison Bath AB Feb 25/10
Director, Employment and Income Assistance Branch

Ministry of Housing and Social Development

Supplements Review
Presentation to the Deputy

October 2009

BRITISH
COLUMBIA
The Best Place on Earth

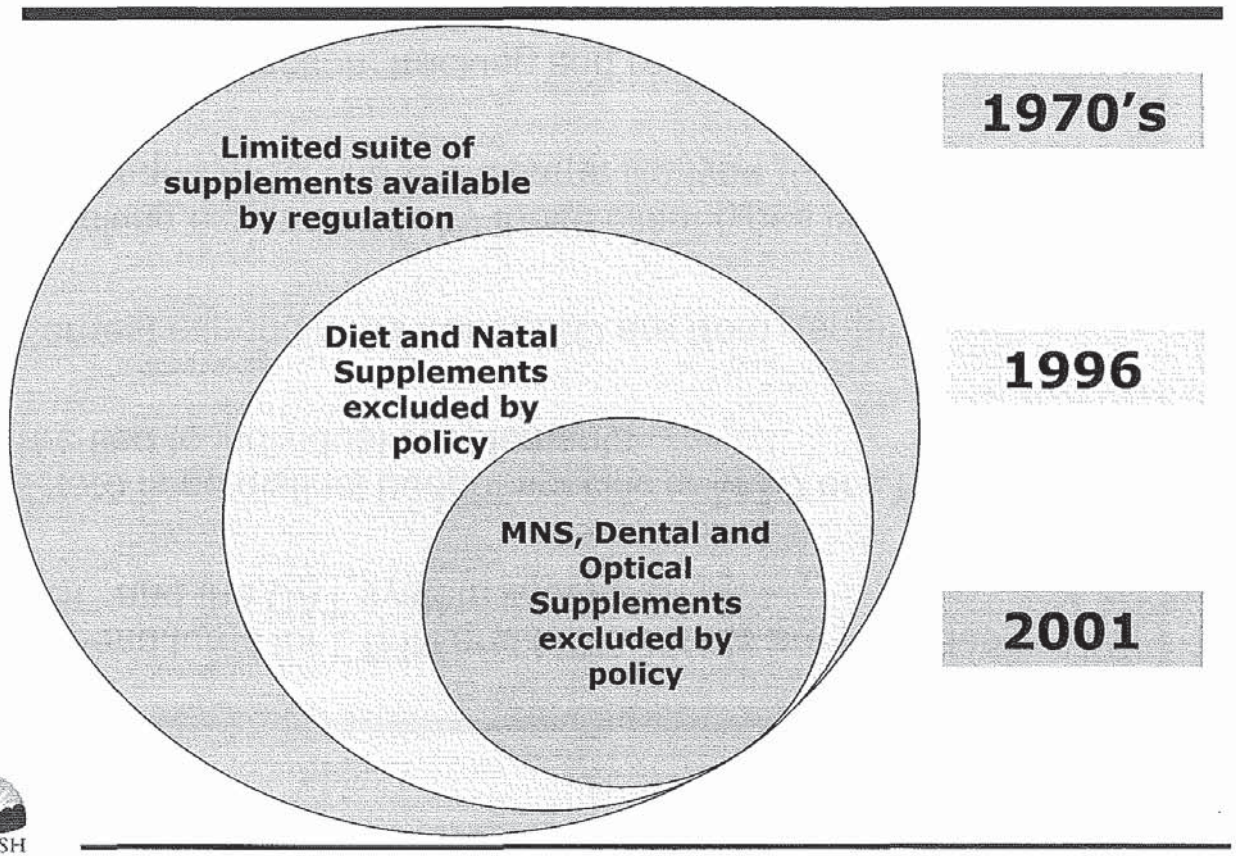
Life Threatening Health Need – Current Policy

Life Threatening Health Need (LTHN) is intended to provide a specific health supplement for any resident of BC (including BCEA clients not otherwise eligible for schedule C, e.g. ETWs), who faces an **imminent** threat to their life and has no other resources to meet that need.

Regulation: Eligible for any schedule C supplement (medical equipment & supplies, dental, optical, extended medical therapies, medical transportation, infant, natal)

Policy: Non eligible items include diet, natal, MNS, nutritional and optical

LTHN – History



BRITISH COLUMBIA
The Best Place on Earth

LTHN – Budget & Expenditures

- Expenditures for LTHN and MSO clients are recorded in MIS, PBC and the CAT system with HAB
- There is no distinct budget specific to MSO or LTHN; budgets are tied to individual supplements
- Largest expenditures from MSO are from dental
- Tracking expenditures by these client types is challenging as LTHN and MSO share the same file type (08) in MIS
- Lack of information, tracking and reporting justifies need for proposed changes

LTHN – Issues

- Combined tracking for MSO and LTHN
  - LTHN files remain open
  - MSP Premium Assistance and Pharmacare are triggered for LTHN cases
- Regulation and policy are not aligned
- Clients demonstrating an indirect threat to their life are accessing supplements through LTHN
- LTHN is not thoroughly income tested

Options

s.13

Options - Improving LTHN Administration

Amend policy and regulation to define LTHN eligibility as: 'for persons who are not otherwise eligible but who face a direct and immediate life threatening health need and have no other resources to meet that need'

- Provides health supplements to those truly face a direct and imminent threat to their life
- Not amending definition creates ambiguity around program intent

Develop a method to track LTHN in MIS, separate from MSO

- Ensures clients receive eligible items only
- Ability to track & report on MSO & LTHN cases and expenditures
- Estimated systems costs - **$43, 000 to $65, 000**

Options – LTHN Eligible Supplements

s.13

Amend regulation to limit eligible items under LTHN to medical supplies, medical equipment and medical transportation:

- Limiting LTHN items provides only necessary health supplements to those who demonstrate a direct and imminent threat to their life
- Regulatory amendment resolves discrepancy between regulations and policy

Options – Income Testing and [redacted] s.13

Income Testing based on MSP Premium Assistance

- Aligns thresholds with existing government programs (Healthy Kids, LTHN and MSP Premium Assistance – which is already in place and is based on tax information)
- Creates a more equitable program based on financial need
- Creating a cut-off point for eligibility could create a gap in service

[redacted] s.13

Options - s.13

s.13

LTHN Recommendation Summary

Regulation

- Amend policy and regulation to define LTHN eligibility as: 'for persons who are not otherwise eligible but who face a direct and immediate life threatening health need and have no other resources to meet that need'
- Limit eligible items under LTHN to equipment, supplies, medical transportation
- Implement income tested for LTHN

s.13

Systems

- Systems change to separate from LTHN cases from MSO

s.13

Estimated systems costs: $43 000 - $65 000
Cost savings: Yes

Life Threatening Health Need – DM Decision Summary

1. **Regulation:**
   - Amend policy and regulation to define LTHN eligibility as: 'for persons who are not otherwise eligible but who face a direct and immediate life threatening health need and have no other resources to meet that need'
   - Limit eligible items under LTHN to equipment, supplies, medical transportation
   - Implement income tested for LTHN based on MSP Premium Assistance

2. **Procedures**
   - s.13

3. **Systems**
   - Systems change to separate from LTHN cases from MSO

4. **Other**
   - s.13

Life-Threatening Health Need

Previous policy	Changes made April 2010	Rationale
• LTHN provided access for non-PWD clients, including non-Ministry clients, to <u>all</u> health supplements available under Schedule C. • The person must face a life-threatening health need and have no other resources available to meet that need. **Issues identified:** • What constitutes a life-threatening health need was not clear. Definitions were not clear. • Many restrictions were in policy and not in regulation. Resulted in inconsistent practice. • No income test.	**Clarified What Items are Available:** • LTHN provides access to medical equipment, medical supplies and medical transportation only. • Health supplements that are not considered necessary to address a life-threatening health need are no longer available. For example, dental, optical, and canes are no longer provided. **Income Testing:** • Introduced income testing based on MSP premium assistance (adjusted net annual income of $30,000) **Clarified What is a LTHN:** • Defined LTHN in regulations to be *direct* and *imminent* health need. • Examples of what is *direct* and *imminent* (and what are not) provided to staff.	• Many items provided did not meet the intent of the policy and were not necessary to address a life-threatening health need. • Clarified what was eligible under the program, making it easier to understand for staff and clients. • Many items previously provided were not directly related to a life-threatening health need – for example, dentures were requested as a LTHN as without dentures they could not eat and would thus starve. This is not a reasonable definition of direct LTHN as there are many options available, • Many items previously provided were not related to an <u>imminent</u> life-threatening health need – for example, people were requesting wheelchairs now to prevent a potential LTHN many years later. Again, not consistent with the intent of the policy. • Aligned regulations with long-standing policies. • Previous determination of financial resources available was not adequate. Linking to MSP premiums assistance establishes a consistent and efficient income-test that is easy to understand and administer. • This prevents people who have financial resources available from accessing LTHN. • Putting the definitions in regulations strengthens the program and reduces inconsistencies. • Defining LTHN to be *direct* and *imminent* helps ensure that only those persons with a real life-threatening health need receive assistance.

<u>Client Impacts</u>:

1. Persons with financial resources who do not meet the MSP premium assistance level will not be eligible for assistance under LTHN.
2. Persons with a non-direct and non-imminent health need will no longer be eligible for assistance under LTHN.
3. Persons requesting items that are no longer provided will no longer be eligible for assistance -- dentures, glasses, canes, etc.

<u>Examples:</u>

Eligible: A person with severe sleep apnea and a serious heart condition can still receive a CPAP device.
A cancer patient who needs transportation for chemotherapy will receive the transportation.

Ineligible: A person requesting a cane to accomplish day-to-day activities is ineligible as their life is not directly or immediately at risk.
A person requesting Tylenol to address headaches. Not eligible supply as defined by the Ministry and person's life is not directly and immediately at risk.

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

DATE: August 13, 2009

PREPARED FOR: Rob Bruce, Executive Director, Strategic Policy and Research Branch

ISSUE: Sustainability of Health Supplement for Medical Equipment

BACKGROUND:

The Ministry of Housing and Social Development (MHSD) provides general health supplements for clients and their families who meet specific eligibility criteria. The medical equipment health supplement provides funding for mobility, positioning, breathing, hearing, and orthotic and bracing items to specific clients who have no other resources to pay for these items. The clients that can access funding include Persons with Disabilities (PWD), Persons with Persistent Multiple Barriers (PPMB), former clients who are Medical Services Only (MSO), dependent children, and persons with a life threatening health need (LTHN). Items must also be pre-authorized by MHSD. Regulation, policy and procedures differ depending on the item requested.

History of Medical Equipment

MHSD has provided funding for medical equipment since the 1940's. In 1945, the Medical Services Division of the Social Welfare Branch, Department of Health and Welfare paid for medical costs for welfare clients. Costs included medical (e.g. doctor visits), drugs, dental, hospital, optical, and transportation. Medical equipment was referred to as "ancillary services" and included artificial eyes, elastic stockings, and surgical appliances of all kinds. Increases in expenditures were noted in 1949/1950 due to a lack of hospital beds. This caused welfare clients to be cared for in their own homes, boarding homes, or nursing homes. Medical supplies were then provided by the Social Welfare Branch as this was their jurisdiction.

Throughout the 1950's, medical equipment continued to be referred to as "ancillary services" and in 1959, the ministry was known as the Department of Social Welfare. In the early 1960's, "ancillary services" was referred to as "medical and surgical appliances." Specific items were not listed and clients were referred to the Red Cross Loan Cupboard for wheelchairs, walkers, crutches, bedpans, urinals, and air cushions. In the late 1960's, policy was amended to state that hospital type equipment such as beds and breathing equipment were not included as welfare health benefits. Further, clients were now referred to the Red Cross Loan Cupboard for "short term" needs. For "long term" situations, the ministry would consider wheelchairs, crutches, and walkers.

In 1971, the ministry was known as the Department of Rehabilitation and Social Improvement then in 1973 changed to the Department of Human Resources. In 1976, the name changed again, no longer a department but now a ministry. The *GAIN Act* was introduced and "ancillary" services were now described as "prescribed nontransferable medical needs." These included braces, artificial limbs and eyes, and surgical supports. Prescribed wheelchairs were also provided and needs were assessed by the Canadian Paraplegic Association. Expenditures for ancillary services in 1976/1977 were $524,832. The 1978 ministry annual report notes a growing demand for electric wheelchairs resulted in an approximate 50 percent increase in costs.

In the early 1980's, medical equipment continued to be funded under "ancillary services" with increasing demand noted for equipment and devices to provide greater mobility in home and long term care. In the mid 1980's, the ministry, now known as the Ministry of Social Services and Housing, owned a limited supply of equipment to loan clients on either a short or long term basis. In 1988/1989, the ministry purchased or leased beds, commodes, mobility aids, respirators, suction units, wheelchairs and other items for a total expenditure of $4,262,714. It was noted that demand

was expected to increase with the downsizing of Glendale and Woodlands mental hospitals. As residents left the institutions, some would require equipment and supplies to allow them to function in private and group homes.

In the early 1990's, the At Home program began. This program provides funding to families of severely disabled children for extraordinary emotional, educational, social, and financial challenges involved in caring for their children at home. In 1992/1993, equipment and supplies were differentiated between programs with a combined cost of 8.4 million. In 1996, the Ministry of Human Resources was established as a separate ministry dedicated to the administration of income support programs. Child protection and family services were transferred to the new Ministry of Children and Family Development (MCFD). The *BC Benefits Act* was established and the 1998 BC Benefits manual indicated the following:

Medical Equipment Intent: To provide essential medical equipment to recipients eligible for Enhanced medical coverage in order to prevent medical or health deterioration and consider and provide, where appropriate, a basic mobility aid to a recipient who is unable to be independently mobile.

Orthotics and Bracing Intent: To provide basic, conservative and medically essential orthotics and bracing to recipients eligible for enhanced medical coverage in order to prevent medical or health deterioration and to assist with basic ambulation.

In 2002, BC Employment and Assistance (BCEA) was introduced which formed the basis for current medical equipment policy and procedures. However, there have been notable policy changes during this time.

Current Policy and Procedures

Mobility

Regulation and policy require the item be prescribed by a medical or nurse practitioner and/or an occupational or physical therapist has performed an assessment that confirms the need for the item requested. The item also must be medically essential for basic mobility. "Medically essential for basic mobility" refers to a client's need for equipment necessary to perform his or her day to day activities in the home and/or community, and required due to a mobility impairment.

Regulation specifically indicates the items that may be requested include canes, crutches, walkers, wheelchairs (manual and power), and personal motorized mobility devices (scooters). Items under $500 are assessed in the regions without a form, while items over $500 are assessed at the Health Assistance Branch (HAB) with a medical equipment request form (HSD2138). Items assessed at HAB are provided through contracted suppliers.

Positioning

Regulation and policy require the item be prescribed by a medical or nurse practitioner and/or an occupational or physical therapist has performed an assessment that confirms the need for the item requested. Regulation does not specifically indicate what is considered a positioning device. This is outlined in policy where wheelchair seating, hospital beds, bathing/toileting aids, and lift devices are the main items available. Items are assessed in the same manner as mobility items and provided through contracted suppliers.

Breathing

Regulation and policy require the item be prescribed by a medical or nurse practitioner and a respiratory therapist (RT) has performed an assessment that confirms the need for the item requested. Regulation does not specifically indicate what is considered a breathing device. This is outlined in policy where Continuous Positive Airway Pressure (CPAP) machines are the main items available.

A CPAP machine treats obstructive sleep apnea, a common sleep disorder caused by obstruction of the airway characterized by pauses in breathing during sleep. The machine stops this phenomenon by delivering a stream of compressed air via a hose to a nasal pillow, nose mask or full-face mask, keeping the airway open under air pressure so that unobstructed breathing becomes possible. All items are assessed at HAB with a medical equipment form (HSD2138). There are no contracted suppliers for breathing items.

Orthotics and Bracing

Orthotics and bracing are orthopedic appliances or apparatuses used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. The ministry funds both lower and upper extremity items. Examples of lower extremity items include foot orthotics, custom and off the shelf shoes, ankle-foot orthotics, and knee braces. Upper extremity items include wrist/hand braces, back braces, neck braces, and helmets.

Regulation and policy require a medical practitioner, podiatrist, occupational or physical therapist to prescribe the item requested. Off the shelf items are to be supplied unless the prescribing professional or a certified orthotist confirms that a custom item is required. Procedures require regional staff to refer the client to an orthotics supplier who completes an orthotics and bracing form (HSD2894) and submits it to HAB. There are no contracted suppliers for orthotics and bracing items.

Recent Impacts to Medical Equipment

2003
Regulation changes increased access to professionals that provide orthotic and bracing items. Occupational therapists (OT), physical therapists, and podiatrists, were added in regulation to provide service. In practice, pedorthists are accepted as well. Previously, orthotists were the only service provider accepted. Other changes included allowing off the shelf items; previously only custom items were considered. The changes were to be cost neutral; however, costs have increased substantially. There have been no further changes to orthotics since 2003.

2006
In February, the BC Government committed to building the best system of support in Canada for persons with disabilities. MHSD was given the lead role in developing and implementing a Provincial Disability Strategy – a group of cross-government initiatives that would create an integrated, citizen-centred system of support.

2007
The Personal Supports project, designed as part of the Disability Strategy to help connect people to assistive devices, launched a toll free information line. The service provides information to individuals on how to access medical equipment and assistive devices from various funding sources, including MHSD. The project subsequently expanded in the following years to include two resource centres in Victoria and Prince George. Individuals are assisted in person and through a website with information on funding sources for medical equipment. The goal of Personal Supports

is to make all community and government programs accessible for everyone, making it easier for British Columbians to participate more fully at home and in the community.

In the spring of 2007, HAB underwent a reorganization that brought together the adjudication of mobility, positioning, breathing, and orthotics/bracing equipment to one team of adjudicators. Previously, adjudication was organized by "level 1" and "level 2" adjudication teams that reviewed various supplement areas that were not related. A specialized medical equipment adjudication team lent itself to adjudicators acquiring greater knowledge and expertise in medical equipment. During this time, direction to adjudicators was to broaden interpretation of eligibility criteria and provide citizen centered service delivery. Currently, direction to adjudicators is to narrow interpretation of eligibility criteria.

2008

In July, in response to concerns from advocates and to support the Disability Strategy, the ministry introduced policy guidelines for the "medically essential for basic mobility" criterion for mobility equipment. The guidelines outline that "medically essential for basic mobility" refers to a client's need for equipment necessary to perform his or her day to day activities in the home and/or community, and required due to a mobility impairment. Previously, the ministry focused primarily on providing mobility equipment for the home environment only.

In November, the ministry amended regulation to improve client access to medical equipment. Nurse practitioners are now recognized to prescribe medical equipment and for mobility and positioning equipment under $500, a client may provide a prescription from a medical or nurse practitioner or an assessment from an occupational or physical therapist. Previously, both a prescription and assessment were required.

DISCUSSION:

The ministry, in its various inceptions, has provided funding for medical equipment for over 60 years. During this time, annual reports show increasing cost pressures. The overall historical trend is that the ministry has taken on more equipment items due to:

- Decrease reliance on community agencies such as the Red Cross Loan Cupboard.
- Increase in types of equipment available such as electric wheelchairs, scooters, and orthotics.
- Lack of funding available through other government agencies such as the Ministry of Health Services (MoHS).
- Increases in persons with disabilities living in the community, rather than long term care hospitals.

Most recently, total expenditures for mobility, positioning, and breathing equipment have grown significantly over the past three years. In 2006/2007, expenditures totaled $11,707,600.70 for items funded through HAB and the regions. In 2008/2009, expenditures increased 30 percent totaling $15,213,987.09. Orthotics and bracing have also shown considerable growth over the past five years. In fiscal 2004/2005, expenditures totaled $1,188,282.91 for items funded through HAB and the regions. For fiscal 2008/2009, expenditures have totaled $2,024,256.35. This is an increase of 70 percent. This ongoing increase in expenditures is risking the long term sustainability of the medical equipment supplement.

Trend Analysis

In order to fully understand the cost pressures facing medical equipment, approval costs and client access were compared over a five year period from 2004/2005 to 2008/2009. The equipment processed through HAB is the basis for this trend analysis (see Appendix A).

Mobility, Positioning, Breathing

Mobility items are primarily manual wheelchairs, power wheelchairs, scooters, and related repairs. In 2004/2005, mobility items accounted for 64 percent of mobility, positioning, and breathing items approved costing $4,535,133.31. In 2008/2009, these items accounted for 56 percent, totaling $7,975,869.90. This is a 76 percent increase in costs but an eight percent decrease in share of items approved. All mobility items have shown considerable growth over five years with power wheelchairs showing an increase of 54 percent, manual wheelchairs increasing 82 percent, and scooters increasing 110 percent. However, it should be noted for scooters that 2004 was a lower cost year. When comparing 2008/2009 to 2005/2006, scooter costs have only increased nine percent.

Positioning items primarily include bathing/toileting aids, wheelchair seating (off the shelf and custom), hospital beds/mattresses, and lift devices. In 2004/2005, these items combined accounted for 31 percent of mobility, positioning, and breathing items totaling $2,106,469.48. In 2008/2009, these items accounted for 34 percent, totaling $4,862,490.35. This is a 131 percent increase in costs and a three percent increase in share of items approved. There are several positioning items that showed notable increases in cost. Custom seating increased 141 percent, hospital beds/mattresses increased 121 percent, and lift devices increased 134 percent.

Breathing items comprise primarily of CPAP and Bi-level Positive Airway Pressure (BiPAP) machines and related supplies. In 2004/2005, these items combined accounted for five percent of mobility, positioning, and breathing items totaling $328,515.81. In 2008/2009, these items accounted for seven percent totaling $933,838.42. This is a 184 percent increase in cost and two percent increase in share of items approved. Specifically, CPAP/BiPAP machines increased 144 percent and CPAP/BiPAP mask and head gear increased 399 percent.

Orthotics and Bracing

Orthotics and bracing are comprised of lower and upper extremity items. Lower extremity items include foot orthotics, custom and off the shelf shoes, ankle-foot orthotics, and knee braces. Upper extremity items include wrist/hand braces, back braces, neck braces, and helmets. In 2004/2005, lower extremity items accounted for 90 percent of orthotics and bracing items totaling $1,142,627.98. In 2008/2009, these items accounted for 93 percent totaling $2,094,464.47. This is an increase of 83 percent over five years. In 2004/2005, upper extremity items accounted for nine percent of total items costing $129,287.45. In 2008/2009, these items accounted for seven percent of items costing $178,426.33. This is an increase of 38 percent.

Other notable increases include foot orthotic items (custom and off the shelf) at 81 percent and shoes (custom and off the shelf) at 206 percent. The most notable year-over-year overall increase occurred from 2007/2008 to 2008/2009. Orthotic and bracing costs increased 33 percent while the previous four years increased on average only 13 percent.

Why the Increase in Costs?

Average Cost per Client

The average cost per client for mobility and positioning equipment increased 10 percent from $4,561.73 in 2004/2005 to $5,024.19 in 2008/2009. For breathing equipment, the average cost per client in 2004/2005 was $1,194.60 while in 2008/2009 it was $995.98. This is a decrease of 17

percent. For orthotics and bracing, the average cost per client in 2004/2005 was $558.30 which increased 24 percent in 2008/2009 to $691.33.

Average Cost per Item

The average cost per item for mobility and positioning equipment increased three percent from $3,609.33 to $3,699.68 over the five year period. Breathing equipment decreased 24 percent from $902.52 to $688.96. Orthotics and bracing increased 18 percent from $506.93 to $600.24.

Increasing Client Access

In 2004/2005, 1,478 BCEA clients[1] received mobility and positioning equipment. This increased 79 percent in 2008/2009 where 2,648 clients received equipment. 275 clients received breathing equipment in 2004/2005 increasing 241 percent to 938 clients in 2008/2009. Clients accessing orthotics and bracing went from 2,309 to 3,295 over the same period which is an increase of 43 percent. The number of items funded per client increased on average 11percent for all equipment.

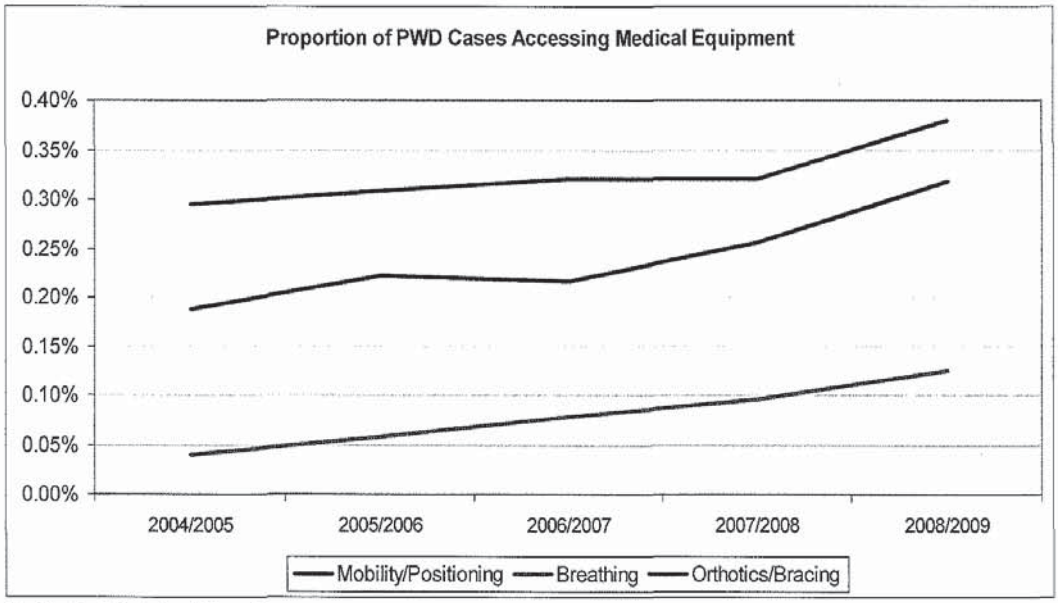
PWD clients receiving disability assistance are the primary BCEA client group accessing medical equipment. In 2008/2009, for mobility and positioning equipment, 76 percent of clients were PWD, followed by MSO/LTHN at 18 percent. For breathing equipment, 77 percent were PWD followed by MSO/LTHN at 13 percent. For orthotics and bracing, 83 percent of clients were PWD followed by MSO/LTHN at eight percent.

The average monthly PWD caseload[2] grew 26 percent from 2004/2005 to 2008/2009 and the monthly average PWD cases that access mobility and positioning equipment increased 114 percent, breathing equipment increased 305 percent and orthotics and bracing increased by 63 percent. This shows that PWD cases accessing medical equipment are increasing faster than the growth of the PWD caseload. It would be expected that as the PWD caseload grows, the proportion of PWD cases accessing medical equipment would remain constant; however, this has not been the case.

The following table and chart illustrate that there has been a significant increase, particularly in fiscal year 2007/2008, in the proportion of PWD cases accessing medical equipment. Although the proportion of PWD cases accessing medical equipment appears low, the cost of that proportion is extremely high. A 0.10% increase can represent millions of dollars.

Average Monthly Cases	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	Percentage Increase
PWD Caseload	53,730	57,524	60,087	64,300	67,836	26%
PWD cases accessing mobility/positioning items	101	128	130	165	216	114%
PWD cases accessing breathing items	21	33	47	62	85	305%
PWD cases accessing orthotics items	158	177	193	206	257	63%

[1] "Clients" refers to distinct individuals receiving assistance.
[2] "Caseload" refers to case files receiving assistance. A case file may contain more than one client.



Shifts in Ministry Direction

Reasons for this proportionate increase of PWD cases and overall increase in expenditures may be as a result of fundamental shifts in ministry direction during the past five years. Some of the changes in the past few years have included:

- Great Goal 3 - In February 2005, the BC Government committed to building the best system of support in Canada for persons with disabilities.
- Provincial Disability Strategy - The disability strategy involves community, including government, working together to support persons with disabilities. The ministry has looked at meeting individual needs using broad interpretations of regulations.
- Client Centred Service – the goal is to ensure that clients get everything they are eligible for in a timely manner. The ministry has made great strides in setting and maintaining service standards.
- Regulation and policy amendments to increase equipment access for clients.

Conclusion

The most notable medical equipment trend over the five year period is the significant continuing increase in overall costs for all items. This appears to be a result of the increasing number of clients, particularly PWD clients, accessing equipment. For example, PWD case access for breathing equipment increased a substantial 305 percent. The increase in PWD access is actually higher than the 26 percent growth rate of the PWD caseload. Further, clients received more items in 2008/2009 than they did in 2004/2005. Shifts in ministry direction since 2006 also have likely played a role as overall equipment costs began increasing rapidly in 2006/2007 when these changes occurred.

Actual cost of medical equipment items appear not to be increasing on the same scale. In fact, the average cost of breathing items decreased and mobility and positioning equipment have only

marginally increased. However, orthotics and bracing have seen more significant increases in average cost per item.

Ministry of Health Services Comparison

The MoHS, through PharmaCare or the Health Authorities, does not fund mobility or positioning equipment. The Health Authorities, through the Home Oxygen Program, do fund some breathing devices such as ventilators but they do not fund items that MHSD provides, such as CPAP machines. For items that are provided through Pharmacare, such as orthotics and prescription drugs, there is a focus on providing basic items and lower-priced (usually generic) drugs to reduce costs and protect PharmaCare for the long term.

PharmaCare funds orthotics and bracing items to children or youth 18 years of age or younger. Coverage is limited to custom leg, body braces and helmets (foot orthotics or shoes are not provided). Prior Pharmacare approval is required for claims exceeding $400. The program's mandate is to help patients achieve or maintain basic functionality. When claims do not clearly fall within the coverage policy, the patient's activity level, physical make up and other factors are taken into consideration on a case-by-case basis. Focus is on providing lower-priced items to reduce costs.

Equipment Funding in MoHS Facilities

MHSD policy states that clients living in care facilities funded by MoHS may not be eligible for medical equipment from MHSD as these needs may be met through MoHS. However, requests for non-transferable personal items such as glasses, hearing aids, orthotics/bracing, specialized wheelchairs and dentures may be considered. This policy is based on the regulatory criterion that the client must have no other resources available to pay for the item. MoHS funding is considered a resource available.

This policy has been a long standing issue between MHSD and MoHS for at least the past 20 years. Historically, MHSD was much stricter in applying this policy where even specialized wheelchairs were not considered. The reasoning behind this policy was that MHSD expected facilities that are funded by MoHS to provide for all aspects of a person's care, including any medical equipment required. However, funding structures in MoHS facilities are very complex and differ between facilities and regions. Health Authorities are provided a budget for residential care facilities and allocate funding depending on regional needs. Funding is provided to licensed and/or non-licensed facilities.

Currently, HAB contacts care facilities to determine whether they have funding available to pay for the medical equipment requested. Requests are considered on a case by case basis if there is no funding available. Requests that are approved are primarily specialized wheelchairs that only the client can use. Common requests that are denied are pressure relieving mattresses. They are seen by HAB as medical treatment and the responsibility of the care facility as they must provide the client a bed and a mattress.

Cross Jurisdictional Comparison

Alberta and Ontario

Overall, BC, Alberta, and Ontario provide medical equipment through two separate programs: an income/disability assistance type program and a health/community supports type program. The key difference between BC, Alberta and Ontario is that most medical equipment in BC is provided

through income/disability assistance. In Alberta and Ontario, most medical equipment is provided through their health/community supports type program which includes a cost share model. See Appendix C for a comparison table between BC, Alberta, and Ontario.

All Albertans and Ontarians have access to these health supplements and are required to pay a portion of the cost based on their income. Generally, the cost share ratio for both Alberta and Ontario is the province funds 75 percent of the cost and the person is responsible for 25 percent. If a person is on an income/disability assistance type program, that program will pay their portion. Further, Ontario and Alberta's income/disability assistance programs still end up funding some equipment not funded by their respective programs available to the general public.

In BC, numerous medical equipment items are provided by MHSD specifically for MHSD clients. A cost share model does not exist and MHSD will fund the entire cost unless the client has other resources available. The general BC population only has access to these medical equipment items if they have a life threatening health need. The MoHS provides some items but with limited access, such as some orthotics items for children only.

Mobility

Alberta:

- The Alberta Aids to Daily Living Program (AADL) funds walkers, walking aids, manual and power wheelchairs, wheelchair accessories, and repairs. AADL does not fund scooters.
- Assured Income for the Severely Handicapped (AISH) funds the AADL cost share portion, crutches, maintenance and repairs of wheelchairs and scooters not funded by AADL.

Ontario:

- The Assistive Device Program (ADP) funds crutches, walkers, specialized pediatric walkers and strollers, manual wheelchairs, power wheelchairs, wheelchair accessories, and scooters. ADP does not fund canes, non-wheeled walkers, repairs, or assessment fees.
- The Ontario Disability Support Program (ODSP) funds the ADP cost share portion, assessment fees, repairs to wheelchairs, scooters, and walkers.

Positioning

Alberta:

- AADL funds wheelchair cushions, bathing and toileting equipment, homecare beds and accessories, patient lifters, pressure reduction overlays, specialized seating devices, transfer aids, and repairs.
- AISH funds the AADL cost share portion, some items not funded by AADL, maintenance and repairs of some items not funded by AADL.

Ontario:

- ADP does not fund hospital beds, mattresses, bath and shower aids (benches, chairs, bath lifts), chair lifts or any lifting devices, commodes, grab bars, raised toilet seats, and repairs.
- ODSP funds the ADP cost share portion, assessment fees, and repairs to lift devices.

Breathing

Alberta:

- AADL funds oxygen therapy, humidity therapy, suction therapy, tracheostomy tubes, home ventilators, bi-level therapy, resuscitator/bagging units for tracheostomy patients, and repairs. AADL does not fund CPAP machines.

- AISH funds the AADL cost share portion and CPAP machines and repairs.

Ontario:

- ADP funds apnea/heart rate monitors (rented only), compressors, drainage boards, positive airway pressure systems (CPAP, APAP, BiLevel), percussors, resuscitators, specified disposable supplies, suction machines, tracheostomy tubes, ventilator equipment, and oxygen saturation monitors (osm) for children and youth age 18 and under. ADP does not fund repairs to breathing devices.
- ODSP funds the ADP cost share portion and assessment fees. ODSP does not fund replacement masks, headgear, etc. for CPAP machines, aerochambers, and peak flow metres.

Orthotics and Bracing

Alberta:

- AADL funds upper and lower extremity orthotic devices, back and abdominal supports, custom/off the shelf footwear, and repairs. AADL does not fund foot orthotics.
- AISH funds the AADL cost share portion.

Ontario:

- ADP funds custom upper and lower extremity orthotic devices. ADP does not fund off the shelf items, foot orthotics, custom or off the shelf shoes, and repairs.
- ODSP funds the ADP cost share portion and assessment fees.

Indian and Northern Affairs Canada (INAC)

INAC social assistance mirrors MHSD medical equipment supplements for non-status clients only. However, most INAC social assistance clients have status so uptake for medical equipment appears minimal. The INAC policy manual still uses language from the BC Benefits era of medical equipment.

Non-Insured Health Benefits (NIHB)

NIHB provides a comprehensive range of medical equipment for person with status including bathing and toileting aids, cushions and protectors, environmental aids, dressing aids, feeding aids, lifting and transfer aids, mobility aids, walking aids and accessories, wheelchairs, and wheelchair cushions and parts. NIHB does not fund items used exclusively for sports, work or education, items for cosmetic purposes, scooters, hospital beds and mattresses, and grab bars permanently fixed.

Pacific Blue Cross (Public Service)

The Public Service extended medical plan covers the following medical equipment:

Mobility

- Canes, crutches, walkers
- Manual and power wheelchairs and scooters (rental or purchases)
  - Must be rented or purchased from a medical supplier
  - A physician's note stating diagnosis, prognosis & exact medical condition
  - An occupational therapist's report
  - Electric wheelchairs and scooters are covered only if unable to operate a manual wheelchair
- Wheelchair Repairs

Positioning

- Manual hospital bed (purchase, rental, repair)
  - Must provide Dr note with diagnosis and prognosis

Breathing

- Aerochambers
- CPAP machine and supplies
  - Dr note required
  - Only covered if diagnosis is sleep apnea
  - A physician's letter or sleep apnea report indicating the medical necessity is required.
- Oxygen and oxygen supplies

Orthotics and Bracing

- Foot orthotics and orthopedic shoes
  - Orthotics, orthopedic shoes and orthopedic shoe repairs have a combined limit of $400.00 per person per calendar year
  - Prescription with medical diagnosis from a physician, podiatrist, physiotherapist, or chiropractor
  - A biomechanical assessment
  - Written confirmation of using a 3-D volumetric model of the feet
- Splints (must provide rigid support)
- Orthopedic braces (must provide rigid support)

Current Issues and Recommendations

In consultation with Provincial Services Branch (PSB) and Regional Services Division (RSD), a review of mobility, positioning, breathing, and orthotics and bracing regulation, policy, and procedures identified numerous issues (see Appendix B for the detailed list). In order to address these issues and for medical equipment to remain sustainable to provide items to clients to meet their medical needs, several policy options are recommended below.

POLICY OPTIONS:

s.13

Option 2: No Other Resources (all items)

Medical equipment funding includes a requirement that there are no other resources available to the persons family unit to pay for the item. This requirement applies to all clients requesting medical equipment, including MSO and LTHN clients. Currently, there are no guidelines available to ministry staff regarding what is considered a "resource." Clients are not consistently assessed whether they have other resources available to pay for the item. Resources can vary from cash available to the family unit to other funding sources such as ICBC or MoHS if the client is living in a MoHS funded facility. The ministry currently does not require clients to access trusts for health supplements, including medical equipment.

Option 2a: Develop policy guidelines regarding what is considered a "resource" with a tighter interpretation. Amend related forms and procedures. (RECOMMENDED)

Implications:

- If policy is not supported by regulation, there is a risk that decisions may be challenged by clients and advocates and overturned at reconsideration.
- Improves consistency of interpretation of what is a "resource".
- Ensures the ministry is the payer of last resort.
- Not Responsive
- Will need to consider MoHS facilities as a resource.
- May increase staff workload. However, other recommendations may offset this increase (e.g. elimination of certain items will reduce overall requests).

s.13

s.13

s.13

s.13

Option 6: Orthotics and Bracing Eligibility Criteria

Current orthotics and bracing regulation is complex and discretion for the type of item rests mainly with the service provider. This results in higher cost custom items being recommended which may not be the most basic item to meet the client's medical need.

Option 6a: Amend regulation to align orthotics/bracing eligibility criteria with the mandate of Pharmacare, including who can be considered an orthotics service provider (RECOMMENDED)

Implications:

- Will allow for a consistent approach to funding orthotics and bracing in BC.
- A revision to eligibility criteria will focus on providing items for basic need.
- Clarifies who can be a service provider e.g. adding pedorthists.
- Revisions to the orthotics and bracing form will be required to align with new eligibility criteria.

Not Responsive

- Will reduce number of overall requests reducing workload.

Option 6b: Eliminate provision of off the shelf shoes (RECOMMENDED)
Currently, MHSD will fund off the shelf orthopedic shoes when all orthotics and bracing eligibility are met. The intent was to provide shoes for clients that were also provided foot orthotics. However, provision of off the shelf shoes has been done outside regulation as they are not considered an orthotic or brace.

Implications:

- Not Responsive
- Negative reaction from clients, service providers, and advocates.
- Supports Pharmacare alignment to provide basic items.
- Will continue to fund custom shoes for persons with severe foot conditions.
- May increase requests for crisis grants for shoes.
- Will reduce number of overall requests reducing workload.

Option 6c: Regulate orthotics and bracing replacement policy (RECOMMENDED)
Currently there is no replacement policy for orthotics and bracing. Items are replaced on a case by case basis even if the item has been lost, stolen, or misused.

Implications:

- Prevents clients from requesting unnecessary replacement.
- Will efficiently allocate funding for items that need to be replaced for medical reasons.
- Not Responsive
- Greater adjudication efficiency as less discretion involved in decision making.

Option 6d: Develop and regulate an orthotics and bracing fee guide (RECOMMENDED)
Currently, MHSD lacks the controls to provide consistent funding to clients. Other jurisdictions, including Alberta, and PharmaCare have fee schedules or guidelines when assessing orthotics and bracing items. Orthotic and bracing fees for items and assessments widely range by service provider.

Implications:

- Will bring consistency and cost efficiency to funding decisions.
- HAB adjudicators will have an official ministry approved resource to base decisions on.
- Greater adjudication efficiency as less discretion involved in decision making.
- Service providers may disagree with fee amounts.
- Clients may be required to pay extra to service providers who do not adhere to fee schedule.
- Consultation with orthotics and bracing professional associations recommended.
- s.13

Option 6e: Eliminate provision of off the shelf s.13 ***foot orthotics (RECOMMENDED)***
Foot orthotics consist of 32 percent of orthotics and bracing items approved. There is a wide range of foot conditions where foot orthotics are recommended for treatment. There is debate in the media whether foot orthotics are truly required in some circumstances or if service providers recommend them to increase profits. [3] As a result, some private insurance companies have limited certain types of foot orthotics or restricted the professionals that can provide them. Pharmacare, Alberta, and Ontario do not provide foot orthotics.

Implications:

- Not Responsive
- Reduction in workload as fewer requests submitted.
- Negative reaction from clients, service providers, and advocates.
- Clients with severe foot conditions can still access custom shoes to meet their needs.
- Dependent children on income assistance with foot conditions that can be corrected with foot orthotics will lose coverage. Foot conditions may worsen as a result.
- Could result in the need for more medical interventions, such as doctor/podiatrist visits (orthotics seen as preventative).

Option 7: Positioning Eligibility Criteria
Option 7a: Amend regulation to list specific items that are considered "positioning devices" and add a "basic medical need" criterion. Explore the following as a possible list: wheelchair seating, bathing/toileting aids, hospital beds/mattresses, and lift devices (RECOMMENDED)

Implications:

- Clarifies to ministry staff, clients, health professionals, and advocates what types of positioning equipment the ministry will consider.
- Greater adjudication efficiency as less discretion involved in decision making.
- Creates consistency in regulatory framework mirroring mobility regulation.
- Stakeholders may disagree with what items the ministry considers are for "positioning".
- Will reduce requests for non-eligible items such as lift chairs that are currently misinterpreted as "positioning" devices.
- Not Responsive
- Adding a substantial medical criteria is consistent with other health supplement regulations.

s.13

Option 8: Breathing Eligibility Criteria
Option 8a: Amend regulation to list specific items that are considered "breathing devices" and add a "basic medical need" criterion (RECOMMENDED)

[3] "Sole Patrol," CBC Marketplace, February 20, 2008, CBC, May 6, 2009 <http://www.cbc.ca/marketplace/sole_patrol/>

Implications:

- Clarifies to ministry staff, clients, health professionals, and advocates what types of breathing equipment the ministry will consider.
- Greater adjudication efficiency as less discretion involved in decision making.
- Creates consistency in regulatory framework mirroring mobility regulation.
- Stakeholders may disagree with what items the ministry considers are for "breathing".
- Not Responsive
- Adding a substantial medical criteria is consistent with other health supplement regulations.

Option 8b: s.13 ***Explore amending regulation to add a medical severity criterion such as "moderate-severe sleep apnea" (RECOMMENDED)***

Implications:

- Will reduce the amount of items approved.
- Greater adjudication efficiency as less discretion involved in decision making.
- Clearly communicates to RTs, suppliers, clients, and ministry staff what can be considered.

Not Responsive

- Supports fiscal accountability for ministry decision makers.

Option 9: Eligible/Non Eligible Items List

The ministry maintains a list of eligible and non-eligible health supplements. The list is a policy resource for ministry staff to make decisions on requested items. It outlines what items can or cannot be considered. There are several items on the eligibility list that are not supported by medical equipment regulation. Examples include electrotherapy devices (TENS machines), glucose monitor, breast pumps, and sharps containers for diabetic needle disposal.

This inconsistent application of the medical equipment regulations creates confusion for staff and clients on what items can be considered.

Option 9a: Eliminate eligible/non-eligible items list, transfer information to related Online Resource topics, and stop paying for non-regulatory items (RECOMMENDED)

The ministry has arbitrarily allowed some items to be eligible without regulatory support over other items. Items without regulatory support are routinely denied and in some cases are very similar items. For example, a blood pressure monitor is regularly denied as it is deemed a diagnostic testing machine with no supportive regulation. A glucose monitor is also a diagnostic testing machine but is an eligible item.

Implications:

- Equipment items are not funded outside regulation.
- Regional staff find the current list format useful and may find it difficult finding information on specific equipment items in the Online Resource.
- Negative reaction from clients and advocacy community.
- Not Responsive

s.13

Option 9c: Replace eligible/non-eligible items list with a regulated catalogue of mobility, positioning, and breathing items, incorporating current funding limits (RECOMMENDED)

Implications:

- Limits available items to basic items.
- Greater adjudication efficiency as less discretion involved in decision making.
- The ministry has greater control regarding the types of items funded.
- Orthotics and bracing not applicable as these items will be controlled under a separate fee schedule.
- Item pricing based on manufacture suggested retail price minus ministry discount if item obtained through a contracted supplier.
- Regulated catalog increases value to ministry staff as a reference tool.
- Not Responsive

RECOMMENDATION:

Implementation of these options will bring the ministry's medical equipment supplement closer in line with the MoHS mandate of providing basic items. The intent is to provide clients with the low cost items to meet their essential basic needs. Changes will be planned in conjunction with changes to Life-Threatening Health Need to ensure costs savings. s.13

Recommended Options
Option 2a: Develop policy guidelines regarding what is considered a "resource" with a tighter interpretation. Amend related forms and procedures.
Option 3a: Eliminate EAW spending authority; centralize adjudication provincially for items under $500

s.13

Option 5a: Amend regulation to eliminate scooters
Option 5b: Amend policy guidelines to tighten the interpretation of "medically essential for basic mobility"
Option 6a: Amend regulation to align orthotics/bracing eligibility criteria with the mandate of Pharmacare, including who can be considered an orthotics service provider

Not Responsive

Option 6b: Eliminate provision of off the shelf shoes
Option 6c: Regulate orthotics and bracing replacement policy
Option 6d: Develop and regulate an orthotics and bracing fee guide
Option 6e: Eliminate provision of off the shelf foot orthotics
Option 7a: Amend regulation to list specific items that are considered "positioning devices" and add a "basic medical need" criterion. Explore the following as a possible list: wheelchair seating, bathing/toileting aids, hospital beds/mattresses, and lift devices

s.13

s.13

Not Responsive

Option 8a:Amend regulation to list specific items that are considered "breathing devices" and add a "basic medical need" criterion
s.13 Explore amending regulation to add a medical severity criterion such as "moderate-severe sleep apnea"
Option 9a:Eliminate eligible/non-eligible items list, transfer information to related Online Resource topics, and stop paying for non-regulatory items
Option 9c:Replace eligible/non-eligible items list with a regulated catalogue of mobility, positioning, and breathing items, incorporating current funding limits
Total potential cost savings:

CONSULTATIONS:

Donna Roland, Health Assistance Branch
Paul Beardmore, Health Assistance Branch
Kim Harder, Reconsideration Branch
Dave McCunn, Provincial Services Branch
Mike Woodcock, Provincial Services Branch
Tamalyn McKean, Regional Services Division
Michael Aldridge, Policy & Program Implementation Manager, Region 1
Michele Lauzon, Policy & Program Implementation Manager, Region 2
Wanda Williams, Policy & Program Implementation Manager, Region 3

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

Nancy Williams, Policy & Program Implementation Manager, Region 4
Robert Thow, Policy & Program Implementation Manager, Region 5
Tyler Mooi, Legislation and Litigation Branch
Cary Chiu, Legislation and Litigation Branch
Michael Turanski, Legislation and Litigation Branch
Nikki Antenbring, Financial and Administrative Services Branch
Michael Nardi, Strategic Policy and Research Branch
Michael Peterson, Strategic Policy and Research Branch
Wenbo Zeng, Strategic Policy and Research Branch
Bart Walman, Strategic Policy and Research Branch
Cheryl de Boer, Ministry of Health Services
Mary Heppner, Disability Services Division

Enclosures: Appendix A- Trend Analysis Supplement
Appendix B- Identified Policy Issues and Options
Appendix C- Cross Jurisdictional Comparison

Approved/Not Approved Date

_____ _____
Rob Bruce, Executive Director, SPRB

Prepared By	**REVIEWED BY:**	**INITIAL**	**DATE**
Mike Ross Policy Analyst 250-356-0068	Dana Jensen Manager, SPRB	_____	_____
	Alison Bath Director, SPRB	_____	_____
	Debi Moreland Executive Director, PSB	_____	_____

Cliff# 153784
Version #
Updated:

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

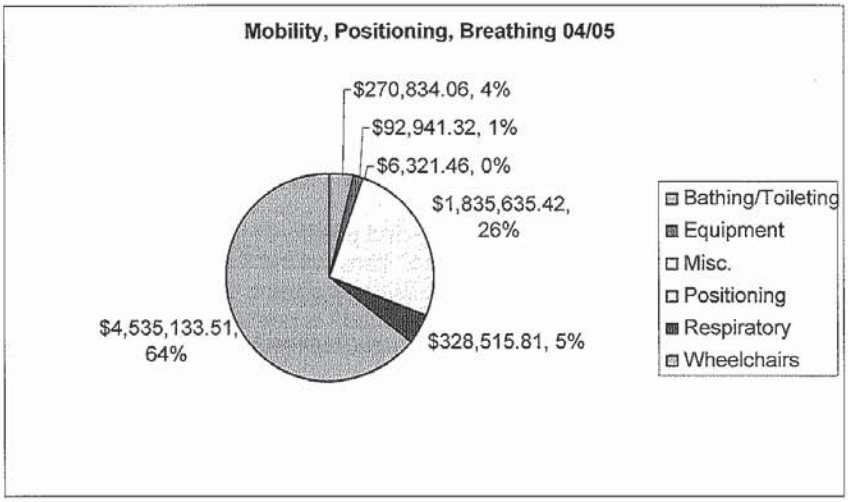
Appendix A – Trend Analysis Supplement

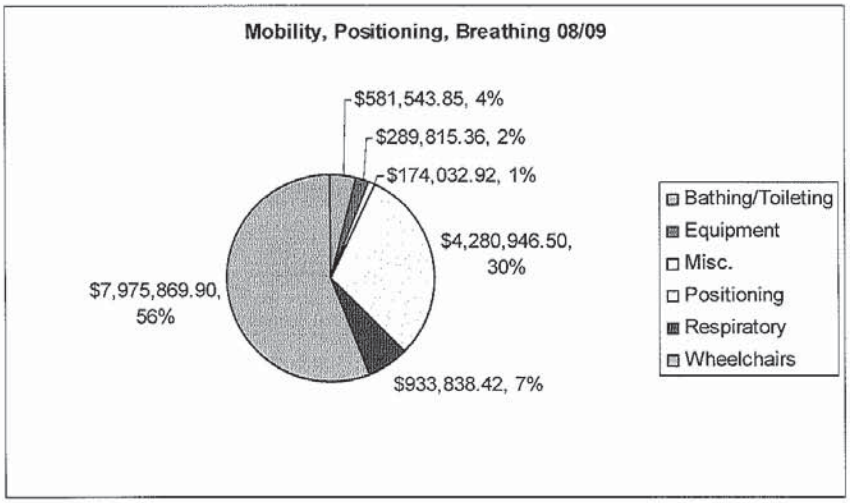
Data Definitions

There were three sources of data for the trend analysis:

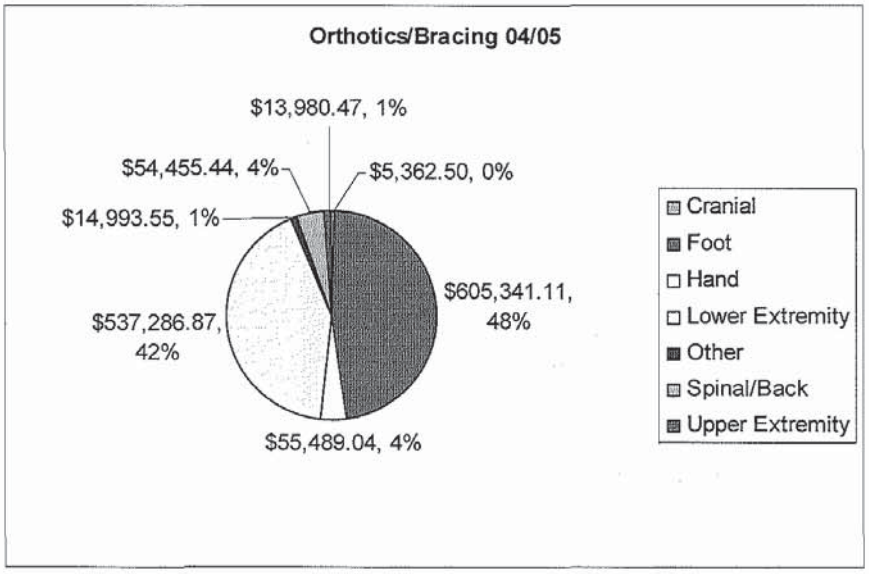
- The Care, Analysis, and Tracking (CAT) system records equipment item types and approval cost amounts for equipment funded through HAB.
    - Approval costs include items that were approved through reconsideration or appeal.
    - Individual analysis for mobility and positioning equipment does not include "equipment" and "misc." items in the CAT system. These items are likely mobility and positioning items but they cannot be distinguished form each other. "Misc." is primarily the 1% administration fee that is paid to the Ministry of Citizen's Services to manage the contract.
- Expenditure information was obtained from the Corporate Accounting Services (CAS) system that processes invoices from both HAB and the regions.
    - Due to invoicing changes in March 2006, comparable expenditure data was not available prior to this date.
    - There is a slight discrepancy between the CAT approval cost and the CAS expenditure amount as not all approvals are invoiced.
    - The expenditure amount is always lower than the CAT approval cost due to requests that are abandoned or changes in the cost when the item is obtained.
- Client program types accessing equipment were determined by matching CAT data to MIS data.

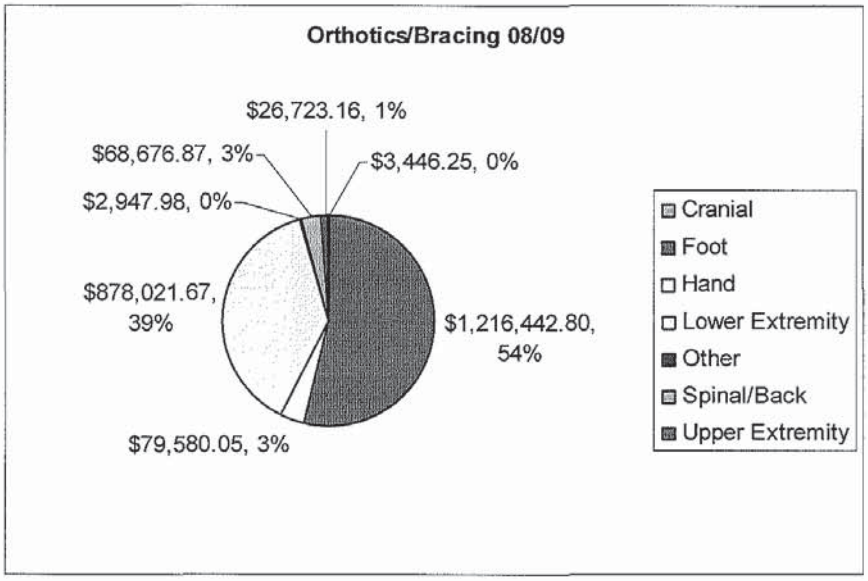
CAT Data Charts

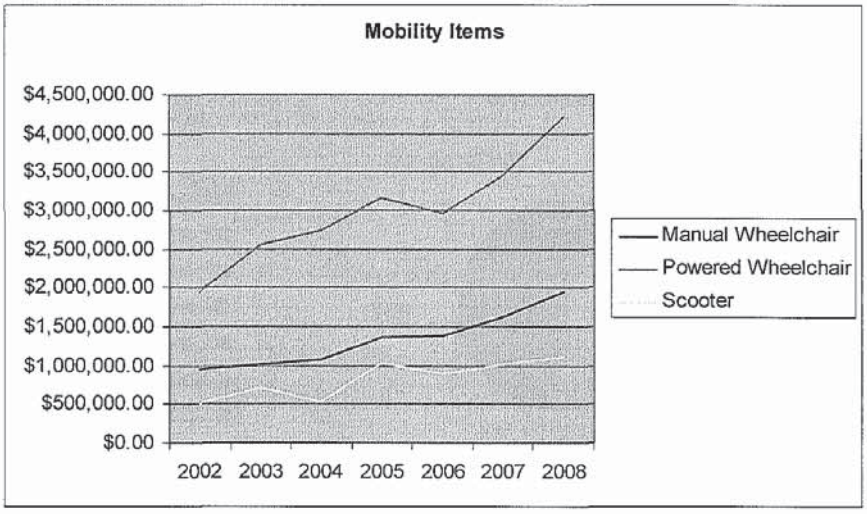


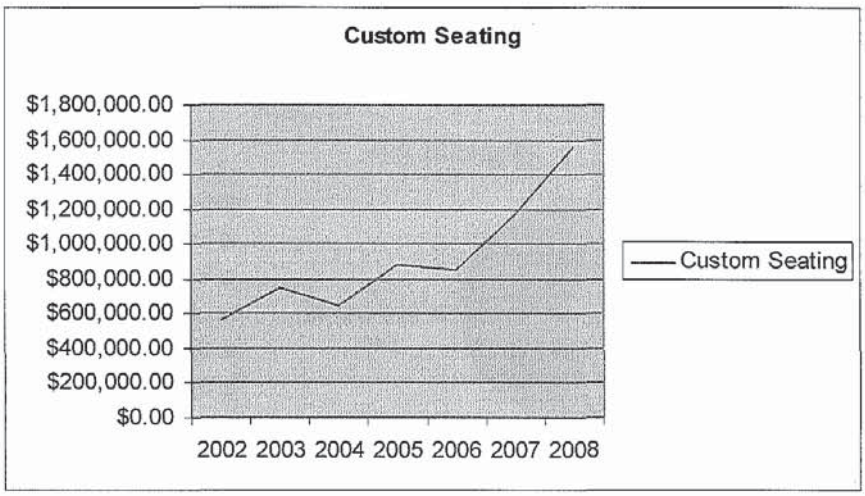


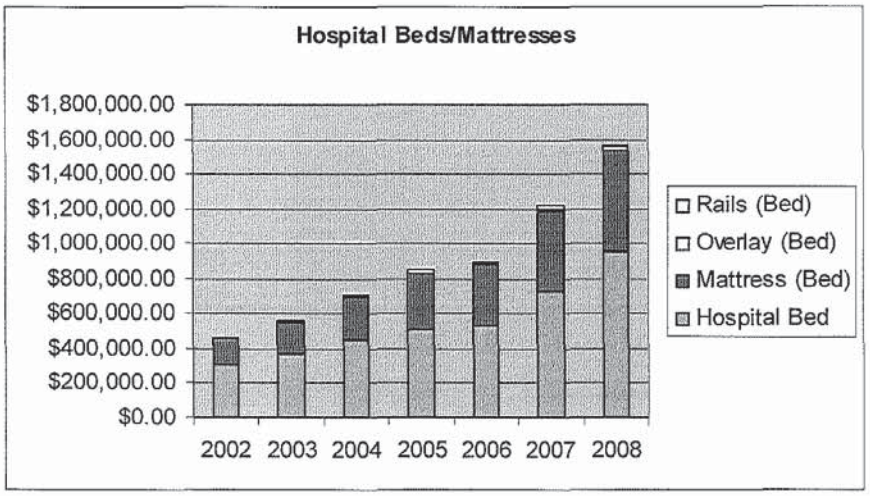
Cliff# 153784
Version #
Updated:

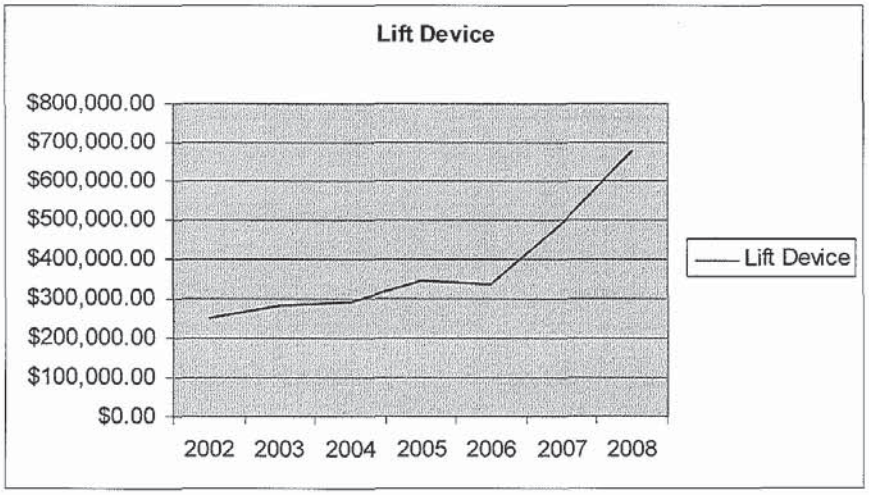

Orthotics/Bracing 04/05
$13,980.47, 1%
$54,455.44, 4%
$5,362.50, 0%
$14,993.55, 1%
$605,341.11, 48%
$537,286.87, 42%
$55,489.04, 4%
Cranial
Foot
Hand
Lower Extremity
Other
Spinal/Back
Upper Extremity

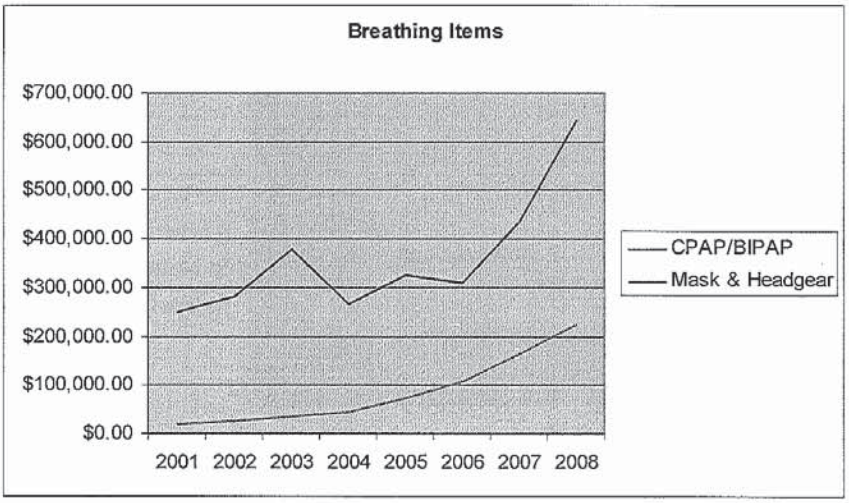

Orthotics/Bracing 08/09
$26,723.16, 1%
$68,676.87, 3%
$3,446.25, 0%
$2,947.98, 0%
$878,021.67, 39%
$1,216,442.80, 54%
$79,580.05, 3%
Cranial
Foot
Hand
Lower Extremity
Other
Spinal/Back
Upper Extremity


Mobility Items
$4,500,000.00
$4,000,000.00
$3,500,000.00
$3,000,000.00
$2,500,000.00
$2,000,000.00
$1,500,000.00
$1,000,000.00
$500,000.00
$0.00
2002 2003 2004 2005 2006 2007 2008
Manual Wheelchair
Powered Wheelchair
Scooter


Custom Seating
$1,800,000.00
$1,600,000.00
$1,400,000.00
$1,200,000.00
$1,000,000.00
$800,000.00
$600,000.00
$400,000.00
$200,000.00
$0.00
2002 2003 2004 2005 2006 2007 2008
Custom Seating


Hospital Beds/Mattresses
$1,800,000.00
$1,600,000.00
$1,400,000.00
$1,200,000.00
$1,000,000.00
$800,000.00
$600,000.00
$400,000.00
$200,000.00
$0.00
2002 2003 2004 2005 2006 2007 2008
Rails (Bed)
Overlay (Bed)
Mattress (Bed)
Hospital Bed


Lift Device
$800,000.00
$700,000.00
$600,000.00
$500,000.00
$400,000.00
$300,000.00
$200,000.00
$100,000.00
$0.00
2002 2003 2004 2005 2006 2007 2008
Lift Device


Breathing Items
$700,000.00
$600,000.00
$500,000.00
$400,000.00
$300,000.00
$200,000.00
$100,000.00
$0.00
2001 2002 2003 2004 2005 2006 2007 2008
CPAP/BIPAP
Mask & Headgear

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

CAT Data Tables

Average Cost per Mobility/Positioning Equipment Client

Fiscal Year	Clients	Total Item Cost	Average Cost
2004-2005	1478	$6,742,229.62	$4,561.73
2005-2006	1827	$8,649,931.93	$4,734.50
2006-2007	1881	$8,583,451.01	$4,563.24
2007-2008	2125	$10,411,910.77	$4,899.72
2008-2009	2648	$13,304,064.52	$5,024.19

Average Cost per Mobility/Positioning Equipment Item

Fiscal Year	Items	Total Item Cost	Average Cost
2004-2005	1868	$6,742,229.62	$3,609.33
2005-2006	2359	$8,649,931.93	$3,666.78
2006-2007	2508	$8,583,451.01	$3,422.43
2007-2008	2827	$10,411,910.77	$3,683.02
2008-2009	3596	$13,304,064.52	$3,699.68

Breakdown of Clients Accessing Mobility/Positioning Equipment by Program

Program	Clients Fiscal Year 2004-2005	Clients Fiscal Year 2005-2006	Clients Fiscal Year 2006-2007	Clients Fiscal Year 2007-2008	Clients Fiscal Year 2008-2009
Misc. (MSO, LTHN)	205	263	299	333	486
CIHR	0	1	1	0	0
ETW	0	2	0	0	2
NEO	10	5	5	3	6
PWD	1034	1296	1313	1615	2023
PPMB	9	4	7	6	6
Long Term Care	219	254	256	168	124
ETWMC	1	2	0	0	1

Notes(s):
Mobility/Positioning Equipment is referred to as "Medical Equipment" in the CAT data minus the following categories / descriptions:
1) Biomedical - (i.e. Feeding Pump, Other, and Suction Machine)
2) Other (Med Equip) - (Hearing Aids only)
3) Respiratory

Average Cost per Breathing Equipment Client

Fiscal Year	Clients	Total Item Cost	Average Cost
2004-2005	275	$328,515.81	$1,194.60
2005-2006	412	$421,859.62	$1,023.93
2006-2007	553	$432,380.18	$781.88
2007-2008	732	$625,895.29	$855.05
2008-2009	938	$934,227.92	$995.98

Average Cost per Breathing Equipment Item

Fiscal Year	Items	Total Item Cost	Average Cost
2004-2005	364	$328,515.81	$902.52
2005-2006	523	$421,859.62	$806.62
2006-2007	739	$432,380.18	$585.09
2007-2008	1022	$625,895.29	$612.42
2008-2009	1356	$934,227.92	$688.96

Breakdown of Clients Accessing Breathing Equipment by Program

Program	Clients Fiscal Year 2004-2005	Clients Fiscal Year 2005-2006	Clients Fiscal Year 2006-2007	Clients Fiscal Year 2007-2008	Clients Fiscal Year 2008-2009
Misc. (MSO, LTHN)	29	38	52	92	118
CIHR	0	0	0	1	1
ETW	9	9	16	16	32
NEO	4	4	5	4	8
PWD	197	316	432	560	721
PPMB	21	23	24	34	36
Long Term Care	6	8	18	17	10
ETWMC	9	14	6	8	12

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

Average Cost per Orthotics Client

Fiscal Year	Clients	Total Item Cost	Average Cost
2004-2005	2309	$1,289,118.36	$558.30
2005-2006	2515	$1,406,957.49	$559.43
2006-2007	2681	$1,624,728.21	$606.02
2007-2008	2699	$1,701,431.79	$630.39
2008-2009	3295	$2,277,920.58	$691.33

Average Cost per Orthotics Item

Fiscal Year	Items	Total Item Cost	Average Cost
2004-2005	2543	$1,289,118.36	$506.93
2005-2006	2767	$1,406,957.49	$508.48
2006-2007	3017	$1,624,728.21	$538.52
2007-2008	3032	$1,701,431.79	$561.16
2008-2009	3795	$2,277,920.58	$600.24

Breakdown of Clients Accessing Orthotics by Program

Program	Clients Fiscal Year 2004-2005	Clients Fiscal Year 2005-2006	Clients Fiscal Year 2006-2007	Clients Fiscal Year 2007-2008	Clients Fiscal Year 2008-2009
Misc. (MSO, LTHN)	170	177	171	190	261
CIHR	19	18	19	22	31
ETW	28	23	24	21	28
NEO	23	24	32	34	47
PWD	1740	1963	2103	2242	2730
PPMB	169	145	119	99	120
Long Term Care	146	152	192	76	67
ETWMC	14	13	21	15	11

Appendix B - Equipment and Supplies Identified Policy Issues and Options
Cliff # 153784

Policy Issue	Options	Regional Perspective
No Other Resources" • Unclear interpretations of what consists as a "resource" • Inconsistent completion of EIA435 Health Needs Request form • Unclear roles and responsibilities of whether regional staff or HAB assess if there are other resources available • Question on 2138 form regarding resources is rarely completed	• Develop guidelines to explain what is considered a "resource" and steps to take to determine if they are available s.13	Region 1: (mso clients) Currently have no allowable financial asset level and no direction or ceiling on permittable other assets: homes/cars/values. If resources are identified by EAW for an item that is HAB authority (ie ongoing supplies) the request is currently still forwarded to HAB since it is still their authority to make a final eligibility decisions because there may be medical considerations (ie ineligible or eligible items) that were not looked at in the financial review. Direction on allowable permittable expenses? Guidelines? (credit card payments, cost of operating multiple autos, cable, internet, food expense guidelines vs unit size). Region 1 mso Team has a good handle on the 435 and docs required **Need to Ensure that HAB is viewing the 435 for EAW recommendation and signature and not just seeing the 435 on file (financial assessment may not be complete) Region 2: Agree with both the policy issues and options. Region 3: EAW should be responsible for completion of 435 and at that time be reviewing income and assets as possible resources. In situations where there are possible resources the client would be requested to submit documents to confirm. Region 4: Guidelines would be most beneficial in what is considered a resource. Region 5: Unclear roles and responsibilities of whether regional staff or HAB assess if other resources are available and what they are. In most cases they are looking at what financial resources are available. **'no other resources' would be a struggle to develop as it is referenced in so many areas of the regs. (eg crisis, CJS, med trans, med equip, orthotics, med trans, etc), each town and client would be unique ** The OLR needs to clear up the r&r as the authority matrix list approval levels then wording changes to 'assess' when it mentions HAB under the life-threatening policy.
Funding limits • Current HAB policy includes funding limits on the following items: o Back up Wheelchairs ($1500.00) o Scooters ($3700.00) o Lift Devices ($4200.00) • Limits are not mentioned on the OLR • Limits are not always enforced and seem to be more of a guideline (e.g. scooter over $3700.00 can be considered if justified)	• Update OLR to include information on funding limits s.13 • Analyze limit amounts to determine if they are reasonable	Region 1: Are the field staff able to access HAB Policy? We were no aware that there was funding limits. Good info for the OLR for field staff to be knowledgeable of. Region 2: Agree with both the policy issues and options. Region 3: If the funding limits and guidelines are on the OLR then the EAW can provided the client with more information, resulting in better service. Region 4: Was not even aware there were funding limits, hence guidelines would be great. Region 5: There are guidelines at HAB that the field does not see or know. When HAB denies we do not know why or hw they assessed. No written guidelines on the OLR, there should be.
Repairs • Current HAB policy generally funds repairs to MHSD funded equipment • Repair policy is not mentioned on OLR • There may be some situations where it is reasonable to fund repairs on equipment not funded by MHSD (e.g. power wheelchair funded by ICBC where client meets all MHSD eligibility criteria) • Tribunal approves a non-eligible	• Clarify repair policy • Update OLR to include information on repairs s.13	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: Concur. Region 4: s.13 Region 5:

item that needs repairs	• "And/or" regulation may allow discretion for less documentation	Needs to be guidelines on who does the repair, cost benefit of repair vs. replacement. Do we assess regular wear versus intentional damage? Shipping costs also need to be calculated into the guides

s.13

MOH facility policy • Equipment funding in MOH facilities is complex and varies depending on the facility • Current policy may be too simplistic to address the funding structure in facilities • Clients may not get the equipment they need if HAB decides the facility should fund it but the facility does not have the funding for it • HAB has more specific MOH policy that is not on the OLR such as: o "Individualized" mobility equipment can be considered o Positioning equipment cannot be considered • Some community OTs are unable to do assessments in facilities which provides challenges for obtaining documentation o Health Authority specific (region 1 can't go into facilities)	s.13 • Update OLR to reflect HAB practice • Consider incorporating into "no other resources" guidelines	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: This requires specific guidelines for these situations or have them referred immediately to HAB to determine funding. This could become too complex for the field and involve too much time. Either we fund or we don't. Region 4: s.13 Ofter clts are denied funding and if facilities cannot afford clts nc without. Consider funding if no alternate resources. Region 5: No comments
Cost of Medical Equipment • Expenditures for mobility, positioning, breathing, and orthotics/bracing are increasing	• Obtain raw CAT data from IMB to complete a trend analysis to identify reasons for cost increases reviewing the following: o PWD caseload increases o Types of equipment requested o Any other relevant factors	Region 1: MSO caseloads increasing due to disability caseload increase and aging population Region 2: Agree with both the policy issues and options. Region 3: No comments Region 4: No comment Region 5: No comments

s.13

Replacement period • Historically, there was an equipment replacement policy of 5 years at HAB • Presently, the replacement period is taken under consideration but is not really enforced as a "policy"	• Update OLR to provide information on replacements s.13	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: Keep it simple as these situations are case by case.

anymore		Region 4: Guidelines would be beneficial Region 5: Tag this item with the "repair" question.
nterpretation of "Positioning Device" • Interpretation varies • The OLR does not clarify what can be considered a "positioning device" • Certain "aids to daily living" or "non-eligible items" may be considered "positioning devices"	• Develop interpretation guidelines for "positioning devices" or propose regulation definition s.13	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: No comments Region 4: OLR VERY unclear better interpretation. Region 5: No comments
nterpretation of "Breathing Device" • There are no guidelines to explain what a "breathing device" is • Humidifier not an eligible item but sometimes approved	• Develop interpretation guidelines for "breathing devices" or propose regulation definition • Consider humidifier an eligible item if medically necessary o Currently, if humidifier is associated with CPAP or built into CPAP then it may be considered	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: Concur. Region 4: Better interpretation Region 5: No comments
CPAP - "Moderate – severe" sleep apnea • Part of HAB guidelines for CPAP adjudication o Other factors may be considered if sleep apnea is not "moderate-severe" • Is policy reasonable? • Not mentioned on OLR	• Review HAB guidelines to determine if "moderate-severe" is reasonable • Update OLR to reflect HAB practices	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: Concur. Region 4: OLR needs to be updated Region 5: No comments
Orthotics/Bracing - Spending Authority • No EAW authority to approve items is inefficient • HAB is sent requests for very low cost items (e.g. $20) • Other equipment items have a $500 limit for EAWs	• Consult with Regional Services Division to revise spending authority. Options include: s.13 o Set dollar limit for EAW e.g. $100 s.13	Region 1: s.13 Region 2: Agree with both the policy issues and options. Region 3: This may be considered an additional workload to the field. Region 4: s.13 Set dollar limit for EAW's Region 5: Agreed. Create a consistent, for all medical supplies, authority matrix. I think the dollar value is best, although this may mean a review down the road as prices increase.
Orthotics/Bracing – Fees • Variable assessment fees (range from $30 to $150) • Variable item fees • Frequent suppliers (e.g. feet expert) charging more than other suppliers • Costs are increasing	• Develop a fee schedule or fee guidelines s.13 o Explore how it would be maintained o Research other fee guides (e.g. Pacific Blue Cross, Insurance Industry, Orthotist Association) s.13	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: No comments Region 4: No comment, little knowledge on subject. Region 5: No comments

equipment		

s.13

Orthotics/Bracing - Basic mobility • Same criteria as medical equipment but has a different interpretation • Tick box question on form limits adjudicator discretion	• Develop interpretation guidelines • Change question on form • Amend regulation to more accurately reflect intent of criteria • Amend regulation to remove as a criteria	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: No comments Region 4: Little knowledge on how decisions are made Region 5: No comments
Orthotics/Bracing - Service Providers • Pedorthists not in regulation but accepted • Chiropractors have requested to be accepted • Historically, HAB policy was to ensure service provide scope of practice was relevant to fit off the shelf or custom orthotics/ bracing item. However, fitting was not a regulatory criteria	• Amend regulation to add Pedorthists s.13	Region 1: No comments Region 2: Agree with both the policy issues and options. Region 3: No comments Region 4: Amend regulation as did not even know pedorthists were accepted Region 5: No comments

s.13

RSD General Comments:

Region 1:
From the MSO Team from Region 1 - Thanks again for asking us to partake in this. We have added our concerns/issues to the 3rd column. If you have any further questions, please do not hesitate to call.

Region 2:
Hi Michael, document looks good. I have added agreement comments in the regional perspective field, but do not have any additions.

Region 3:
Mike, I have had difficulty getting anyone to complete this due to volume issues however Paula and Penny were finally able to look at it and their comments are below.

Region 4:
No additional comments

Region 5:
Michael

It does raise questions. I have added some comments into your chart. What you present and the insight from HAB is well written. Much of these issues need the experience and knowledge of the equipment and the conditions that require equipment. Often what we find is the Dr are not specific, they provide / request only what the patient wants and not what we are able to pay / provide. The letters and notes form Drs are terrible. If you provide the EAW with the approval authority for some items, there may be an increase in reconsiderations (seen as the EAW doe not have the expertise to make a decision.) Currently the number of tribunals in front of HAB decisions is increasing. It may be an idea that all tribunals are attended by HRB and not the field. If you have any questions let me know

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
POLICY OPTIONS NOTE

Appendix C – Cross Jurisdictional Comparison

	British Columbia		Alberta		Ontario	
	Ministry of Housing & Social Development - PWD	Ministry of Health Services/Health Authorities	Ministry of Seniors & Community Supports - Assured Income for the Severely Handicapped	Ministry of Seniors & Community Supports - Alberta Aids to Daily Living (cost share model)	Ministry of Community & Social Services - Ontario Disability Support Program	Ministry of Health & Long Term Care - Assistive Device Program (cost share model)
Canes	X		X	X		
Crutches	X			X		X
Walkers	X			X		X
Manual/Power Wheelchairs	X			X		X
Scooters	X					X
Hospital Beds/Mattresses	X			X		
Bathing/Toileting Aids	X			X		
Patient Lift Devices	X			X		
CPAP	X		X			X
Foot Orthotics	X					
Custom Shoes	X			X		
Off the Shelf Shoes	X			X		
General Bracing	X	X[1]		X		X[3]
Repairs	X		X	X	X	
Hearing aids	X	X[2]		X		X
Communication aids				X		X
Visual aids						X
Prosthetics		X		X		X

Notes

[1]Lower extremity custom bracing for children with congenital conditions only

[2]Children under 3 ½ years of age with permanent hearing loss

[3]Custom only

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

DATE: March 19, 2010

PREPARED FOR: Cairine MacDonald, Deputy Minister

ISSUE: Medical Equipment and Supplies Implementation Strategy

BACKGROUND:
The Ministry of Housing and Social Development (MHSD) provides general health supplements for clients and their families who meet specific eligibility criteria. The ministry has recently updated several health supplements, including medical equipment and supplies, to ensure programs for low-income British Columbians are sustainable and provide benefits to as many as possible.

Effective April 1, 2010, regulatory amendments will introduce specific types of medical equipment and categories of medical supplies that can be considered. A list of eligible items will be removed from the ministry's website as the intent is that only items outlined in regulation will be provided.

Only the following types of medical equipment will be considered:

- Canes, crutches, walkers, wheelchairs, wheelchair seating systems, scooters, bathing/toileting aids, hospital beds, floor or ceiling lift devices, positive airway pressure devices, orthoses, and hearing aids.

Only the following categories of medical supplies will be considered:

- Wound care, ongoing bowel care due to loss of muscle function, catheterization, incontinence, skin parasite care, limb circulation care.

The regulatory change provides clarity on what items are covered, reduces some duplication of services and eliminates payment for non-eligible items.

DISCUSSION:
During the policy development phase, the ministry attempted to identify all items that did not have regulatory support. However, medical equipment and supplies are often issued on paper forms (HSD407) done through the regions and through Product Distribution Centre when approved through Health Assistance Branch (HAB). As the exact items provided by HSD407 are not tracked in an electronic format, minimal data was available to show all items the ministry provided. Consultations with HAB and Regional Services were used to identify items.

In addition, the Ministry was able to use the eligible items list in the Online Resource to help determine what items were being provided. The list was developed over 20 years ago and there have since been significant changes in the provision of health items in BC. For instance, Fair Pharmacare was introduced which provides items such as diabetic supplies to low income British Columbians and the home oxygen program was created through the health authorities to provide oxygen and oxygen related equipment (e.g. ventilators). Since the announcement of the April 1st changes, ministry staff have identified several items that should also be considered in the regulation when it is next updated six months from now as part of the ministry's regulatory process.

Food thickeners
Food thickeners are provided to assist persons who have difficulty chewing and swallowing (also called dysphagia). Dysphagia can be life threatening for elderly people and people with cerebral

palsy and muscular dystrophy. Currently, food thickener is not an eligible item but has been provided in practice. It is estimated that 200 clients receive thickeners annually Not Responsive

Suction units and related supplies

A suction unit may be used to clear the airway of blood, saliva, vomit, or other secretions so a person may breathe. Suctioning can prevent pulmonary aspiration (the entry of secretions or foreign material into the trachea and lungs), which can lead to lung infections. This item is commonly used by persons with Cystic Fibrosis. Pharmacare, under plan D, provides digestive enzymes and other products to persons with Cystic Fibrosis but not suction units. It is estimated that 20 clients receive a suction unit and supplies annually Not Responsive

Not Responsive

Percussors

A percussor is an electronic device that produces a striking motion for dislodging and loosening pulmonary secretions in a person's chest. This item is commonly used by persons with Cystic Fibrosis. Pharmacare, under plan D, provides digestive enzymes and other products to persons with Cystic Fibrosis but not percussors. It is estimated that 10 clients receive a percussor annually

Not Responsive

Lancets

A lancet is a pricking needle used to obtain drops of blood for a person with diabetes to test their blood glucose levels. Pharmacare provides needles, syringes, test strips, and insulin through a diabetic supplies program but does not provide lancets. It is estimated that 1,200 clients receive lancets annually Not Responsive

Implementation Plan

To ensure the ministry is providing items to meet the essential needs of our clients and low-income British Columbians, the ministry will actively monitor all medical equipment and supplies requests for the next six months. The intent is to ensure that clients will avoid undue health risks by not providing a particular item.

Regional staff will be directed to send requests for items that are not clearly eligible under the new policy to Health Assistance Branch (HAB) for review. HAB staff will track these items and make a decision to approve on a case by case basis. The Employment and Income Assistance Branch will work closely with HAB to ensure that the basic medical needs of clients are met. After six months, the types of items, medical need, and cost will be analyzed to contemplate a change in regulation to provide them.

During this six month review, the ministry could pursue options with the Ministry of Health regarding the most appropriate government approach to the provision of these items.

s.13

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

s.13

Option 2: Actively monitor for six months requests for items previously approved that are not eligible under the new regulations. Develop interim policy to provide food thickeners, suction machines and related supplies, percussors, and lancets for the six month review period.

Implications:

- Minimizes undue health risks to clients

s.13

- Provides an opportunity to discuss with Ministry of Health Services whether they can provide non-eligible items (e.g. lancets through Pharmacare's diabetic supplies program or suction units/percussors through Pharmacare's plan D)
- Possible increase in HAB workload

RECOMMENDATION:

Option 2: Actively monitor for six months requests for items previously approved that are not eligible under the new regulations. Develop interim policy to provide food thickeners, suction machines and related supplies, percussors, and lancets for the six month review period.

Approved/Not Approved Date:

_____ _____

Cairine MacDonald
Deputy Minister

Prepared by:	Reviewed By:	Initial:	Date:
Mike Ross Policy Analyst, EIAB 250-356-0068	Dana Jensen Manager, EIAB	_____	_____
	Rob Bruce Executive Director, EIAB	_____	_____
	Heather Davidson Assistant Deputy Minister, RSD	_____	_____
	Molly Harrington Assistant Deputy Minister, PRD	_____	_____

Medical Equipment: General Overview

Previous Policy	Changes made April 2010	Rationale
• The Ministry provided funding for medical equipment to specific clients who have no other resources to pay for these items. **Issues identified:** There was a lack of clarity in the policy and regulations over who could receive medical equipment, under what circumstances they could receive medical equipment, and the types of equipment they could receive. Consequently, the Ministry was providing medical equipment that was beyond what clients required. Specifically: • There was no overall intent statement for medical equipment policy. • Regulation did not include sufficient definitions for terms such as "positioning," "breathing," and "medical supplies." • Regulation did not include sufficient medical criteria for "positioning" and "breathing" equipment. • There was no information regarding what type of medical equipment could be considered (e.g. type of wheelchair).	**Must be Least Expensive:** • The equipment must be the least expensive that is appropriate for the purpose.	• Ensures clients receive the most basic, least costly items that meet their medically essential needs.
	Types of Items Covered are Specified: • Introduced revised eligibility criteria specifying the types of items that may be considered. • Some items no longer covered include electrotherapy devices and diagnostic testing devices.	• Regulation specifies what medical equipment can be considered to ensure only medically required equipment is provided. • Eliminates many non-medically essential items – e.g. accessories for scooters, wheelchairs for recreational use.
	Funding Limits Established: • There are now funding limits for the following: o Scooters: $3500 o Ceiling lift devices: $4200 (there is also discretion for a higher amount for unusual installation)	• Ensures clients get only the basic equipment that meets their needs. • Prevents requests for high-end equipment. • Limits determined based on research of the actual costs of equipment available. • Aligns policy with practice.
	Replacement Criteria Established: • Replacement criteria moved from policy to regulations.	• Aligns regulations with policy. • Ensures clients and staff have full information about replacement periods. • Equipment replacement periods are consistent with other jurisdictions and private insurance • Staff have better information to make the correct decision.
	Guidelines to Staff/Application Changes: • Guidelines provided to ministry staff on the following terminology: basic mobility, moderate to severe sleep apnea, and no other resources. • Form redesigned	• Clients, health professionals, advocates, and Ministry staff will have a clearer understanding of what items are available and what criteria are required. • Streamlines the application process (no changes to medical practitioner questions).
Client Impacts:	1. Changes were not targeted at any specific group. 2. Some clients are not eligible for medical equipment that is no longer provided by the Ministry. 3. Clients are no longer be eligible for high-end, expensive medical equipment or accessories that are not medically essential for their needs – e.g. recreational vehicles (ATVs), baskets and flags for scooters.	

Medical Supplies: General Overview

Previous Policy	Changes made April 2010	Rationale
• Disposable medical and surgical supplies are provided to eligible recipients in order to avoid an imminent and substantial danger to health. • The supplies are used in a medical procedure or treatment **Issues identified:** There was a lack of clarity in the policy and regulations over what types of supplies clients could receive. Specifically: • There was no overall intent statement for medical supplies policy. • There was no information regarding what types of medical supplies could be considered. • There was a duplication of services for some items (e.g. contraceptives)	**Eligibility Criteria:** • Amended regulation to specify the purposes in which medical supplies can be considered • The supplies are required for categories of purposes, including, wound care, ongoing bowel care required due to loss of muscle function, catheterization, incontinence, skin parasite care or limb circulation care ❖ Lancets and food thickeners are available by policy • The supplies must be the least expensive appropriate for the purpose • The supplies may now be reusable where appropriate • "Prescription medication" was added to regulation as an item not provided • Guidelines provided to ministry staff on the following terminology: imminent substantial danger to health, no other resources, and reusable where appropriate.	• Clients, health professionals, advocates, and ministry staff will have a clearer understanding of what items are available and what criteria are required • Ensures clients most in need of medical supplies receive least costly items to meet a medically essential need
	Item Coverage: • Some items such as contraceptives devices are no longer covered	• Alternate sources of funding available for items no longer considered such as contraceptives.
Client Impacts:	1. Changes were not targeted at any specific group. 2. Some clients are not eligible for medical supplies that are no longer provided by the Ministry. 3. Reusable supplies are now considered	

Medical Equipment Still Provided

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Canes, crutches, walkers	• No changes – policy aligning with regulation. • Must be medically essential to achieve or maintain basic mobility. • Replacement period: as needed.	• No changes in criteria – these items were already specified in regulation. **Impact on Clients:** • **None.**	**Alberta:** • **Comparable to BC, although more time limited.** • Provided same equipment, once every four years – BC is as needed. • Based on medical criteria – same as BC. **Ontario:** • **Less comprehensive than BC.** • Provides crutches and walkers. Does not provide canes or non-wheeled walkers – BC provides all.
Manual and Power Wheelchairs	• No changes – policy aligning with regulation. • Must be medically essential to achieve or maintain basic mobility. • High performance wheelchairs for recreational sports are not covered • 5 year replacement period	• This change aligns policy and regulation. • Replacement periods were not previously prescribed in regulation. 5 years reflects reasonable wear and tear based on continuous use and is consistent with other jurisdictions. • High performance recreational wheelchairs are not medically essential. **Impact on Clients:** • None.	**Alberta:** • **Comparable to BC.** • Use recycle pool first -- BC purchases new. • Applicants choose from an approved products list. • Replace when outgrown, medical condition changes, or too costly to repair – BC is 5 years. • Program retains ownership – BC it becomes property of client. **Ontario:** • **Comparable to BC.** • Wheelchairs are provided. • Provide the most basic and essential equipment.
Wheelchair Seating Systems	• Must be medically essential to achieve or maintain a	• No changes in criteria – these items were **not** previously specified in regulation.	**Alberta:** • **Comparable to BC.** • Seating systems provided.

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • **Alberta Aids to Daily Living Program (Community Supports Ministry)** • **Ontario Assistive Device Program (Health Ministry)**
	person's positioning in a wheelchair (no change – policy aligning with regulation.) • 2 year replacement period (New)	• Replacement periods were not previously prescribed in regulation. 2 years reflects reasonable wear and tear based on continuous use. **Impact on Clients:** • **None.**	• Replacement as needed – BC is 2 years. **Ontario:** • **Comparable to BC** • Provides positioning devices (cushions, back and head supports, etc.)
Scooters	• $3,500 cost limit implemented (New). • Only medical essential accessories will be provided (New). • 5 year replacement period established in regulations (New).	• Scooters were previously provided but policy did not have full regulatory support. • Criteria ensure ministry provides medically necessary equipment and does not purchase recreational vehicles (ATVs). • Cost limit prevents purchase of high-end (deluxe) equipment. • Replacement periods were not previously prescribed in regulation. • Replacement periods were not previously prescribed in regulation. 5 years reflects reasonable wear and tear based on continuous use and is consistent with other jurisdictions. **Impact on Clients:** • **Minimal**. If required, clients who had received a higher end or non-essential item will be permitted a replacement which meets the new regulation.	**Alberta:** • **Not provided.** **Ontario:** • **Comparable to BC.** • Scooters are provided. • Provide only the most basic equipment, if deemed medically essential.

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
		Identified in Review: s.13	
Bathing and Toileting Aids • a grab bar in a bathroom • a bath or shower seat • a bath transfer bench with hand held shower • a tub slide • a bath lift • a bed pan or urinal • a raised toilet seat • a toilet safety frame • a portable commode chair • a floor to ceiling pole in a bathroom	• No changes – policy aligning with regulation. • Must be medically essential to facilitate transfers of a person or to achieve or maintain a person's positioning. • 5 year replacement period	• No changes as policy aligning with regulation. **Impact on Clients:** • None Identified in Review: • s.13	**Alberta:** • **Less comprehensive than BC.** • Provide less equipment than BC – no hand held showers, tub slides, bed pans, urinals, or floor to ceiling bath poles. **Ontario:** • **Less comprehensive than BC.** • Do not fund bath and shower aids (benches, chairs, bath lifts), chair lifts or any lifting devices, commodes, grab bars, raised toilet seats, and repairs.

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Hospital Beds	• No changes – policy aligning with regulation • Must be medically essential to facilitate transfers of a person to and from bed or to adjust a person's positioning in bed • 5 year replacement period	• No changes as policy aligning with regulation. **Impact on Clients:** • **Minimal.** If required, clients who had received a higher end or non-essential item will be permitted a replacement which meets the new regulation.	**Alberta:** • **Comparable to BC.** • Beds are provided. • Will use recycled beds – BC provides new beds. **Ontario:** • **Not provided.** • Do not fund hospital beds.
Pressure Relief Mattresses	• No changes – policy aligning with regulation • Must be medically essential to prevent skin breakdown and maintain skin integrity • 5 year replacement period	• No changes as policy aligning with regulation. **Impact on Clients:** • **None.**	**Alberta:** • **Comparable to BC.** • Mattresses are provided. **Ontario:** • **Not provided.** • Do not fund mattresses.
Floor or Ceiling Lift Devices	• Lifts were provided under previous policy, but did not have full regulatory support. • $4,200.00 cost limit implemented. Clients with excess costs as a result of unusual installation expenses can receive a higher limit (New). • 5 year replacement	• Cost limit prevents purchase of high-end (deluxe) equipment. • Replacement periods were not previously prescribed in regulation. 5 years reflects reasonable wear and tear based on continuous use and is consistent with other jurisdictions. **Impact on Clients:** • **None.**	**Alberta:** • **Comparable to BC.** • Floor lift devices only – BC also does ceiling lifts. **Ontario:** • **Not provided.** • Do not fund any lifting devices.

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Positive Airway Pressure Devices	• Must be medically essential for the treatment of moderate to severe sleep apnea (New). • Must be prescribed by a medical practitioner or nurse practitioner and the medical need must be confirmed by a respiratory therapist (New). • 5 year replacement period (1 year for related supplies).	• Positive Airway Pressure Devices were previously provided as "breathing devices" for the listed purpose, but policy did not have full regulatory support. • Criteria ensure ministry provides medically necessary equipment only, and does not duplicate breathing devices available through the health care system (such as home oxygen, ventilators) • Replacement periods were not previously prescribed in regulation. **Impact on Clients:** • **Minimal**. If required, clients who had received a higher end, duplicate or non-essential item will be permitted a replacement which meets the new regulation.	**Alberta:** • **Less comprehensive than BC.** • Do not provide CPAP machines – BC provides Bi-level PAP and CPAP. **Ontario:** • **Comparable to BC.** • Provide both Bi-level PAP and CPAP – same as BC.
Suction Machines	• Replacement period: as needed	Assists individuals with airway clearance (commonly used by those with Cystic Fibrosis). **Impact on Clients:** • **None.**	**Alberta:** • **Comparable to BC.** • Suction machines are provided. **Ontario:** • **Comparable to BC.** • Suction machines are provided.
Percussors	• Replacement period: as needed	Commonly used by those with Cystic Fibrosis to assist with airway clearance. **Impact on Clients:** • **None.**	**Alberta:** • **Not provided.** • Percussors are not provided. **Ontario:** • **Comparable to BC.** • Percussors are provided.

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Nebulizers • **Medication delivery device that administers medication in the form of a mist inhaled into the lungs**	• Nebulizers were previously provided and were removed as ineligible item. Mis-information was provided that Pharmacare provides them when packaged with eligible drugs.	**Identified in Review:** s.13 **Impact on Clients:** • **Minimal.** s.13	**Alberta:** **Ontario:**
Positioning items in bed • **Items such as symmetrikit and sidelyers to assist with positioning in bed**	• Items were not identified to be included in regulation changes	**Identified in Review:** s.13 **Impact on Clients:** • **Minimal.**	**Alberta:** **Ontario:**

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Transfer Belts • **Assists in helping a person get up/sit down**	• Item was not identified to be included in regulation changes	**Identified in Review:** s.13 **Impact on Clients:** • **Minimal.**	**Alberta:** **Ontario:**
Orthoses - Dennis Brown boots or foot abduction orthosis • **Brace primarily for correcting club foot in children**	• Item was not identified to be included in regulation changes	**Identified in Review:** s.13 **Impact on Clients:** • **None**	**Alberta:** **Ontario:**

Medical Supplies Still Provided

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
• **Wound care supplies** • **Ongoing bowel care supplies required due to loss of muscle function** • **Limb circulation care supplies** • **Catheterization supplies** • **Incontinence supplies** • **Skin parasite care supplies**	• No changes	• Policy aligning with regulation **Identified in Review:** s.13 **Impact on Clients:** • **Minimal.** Specifying what items can be funded provided clarity to what can be requested.	**Alberta:** • **Comparable to BC** • Items include: o Burn garments o Compression stockings o Dressings o Incontinence supplies **Ontario:** • **Comparable to BC** • Surgical supplies and dressings include: o accessories (adhesives, skin barriers) o catheters o colostomy, ileostomy and urinary supplies o condoms o diapers o drainage bags o incontinence and ostomy supplies o other surgical supplies as required
Lancets	• No changes	• Provided by policy, not regulation **Identified in Review:** s.13 **Impact on Clients:**	**Alberta:** • **Comparable to BC** • Not provided directly. Alberta provides funding to Canadian Diabetes Association Monitoring for Health Program • Monitoring for Health provides financial assistance, not actual items so lancets are not explicitly stated as an eligible item. **Ontario:**

		• None	• Comparable to BC • Ontario provides funding to the Canadian Diabetes Association Monitoring for Health Program to help with the costs of blood glucose meters, **lancets** and test strips
Food Thickener	• No changes	• Provided by policy, not regulation **Identified in Review:** s.13 **Impact on Clients:** • None	**Alberta:** **Ontario:**

Tracheostomy supplies	• Not identified as an eligible item as was being provided by practice	• Provided by policy, not regulation
		
		Identified in Review:
		
		s.13
		
		Impact on Clients:
		
		• **Minimal.** Voice prosthesis items are not being provided. Communication devices have never been an eligible item.
			Alberta:
			
			Ontario:
			
			• **More comprehensive than BC**
			• Respiratory Supplies/Equipment
			  o tracheostomy tubes
			• Communication Devices
			  o electrolarynges
			  o communication boards
			  o mounting systems for communication aids
			  o teletypewriters
			  o voice amplifiers
			  o voice output communication aids
			  o voice prostheses
			  o writing aids

Medical Equipment and Supplies No Longer Provided

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Walking poles	• Were never provided – change is to align policy with long-standing practice. • Canes, crutches and walkers provided to those who have a medical need to achieve or maintain basic mobility.	• **None.** Canes and walkers are still provided.	**Alberta:** **Ontario:**
Strollers	• Were never provided – change is to align policy with long-standing practice. • Not medically necessary.	• **None.** Strollers are not essential medical equipment.	**Alberta:** **Ontario:**
High performance wheelchair for recreational or sports use	• Not medically necessary. Wheelchairs are for basic mobility purposes only, not sports/recreational use.	• **Minimal.** Basic wheelchairs are still provided. • Under previous policy a few clients received high performance wheelchairs, as policy could not exempt them. They will no longer be provided.	**Alberta:** **Ontario:**
Scooters intended primarily for recreational or sports use (e.g. ATVs)	• Not medically necessary. Scooters are for basic mobility purposes only, not sports/recreational use.	• **Minimal.** Basic scooters are still provided. • Under previous policy a few clients received scooters for recreational use (e.g. ATVs), as policy could not exempt them. They will no longer be provided.	**Alberta:** **Ontario:**
Automatic turning beds	• Were never provided – change is to align policy with long-standing practice.	• **None.** Were never provided.	**Alberta:** **Ontario:**

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Containment type beds	• Were never provided – change is to align policy with long-standing practice.	• **None.** Were never provided.	**Alberta:** **Ontario:**
Ventilators	• Were never provided – change is to align policy with long-standing practice. • Ventilators available through the Ministry of Health.	• **None.** Ventilators were never provided by the Ministry. • Clients with a medical need may be provided with a ventilator through the Home Oxygen Program (Ministry of Health).	**Alberta:** **Ontario:**
Manual Breast Pumps	• Not medically essential	• **Minimal.** Very few actually provided. Only 2 cases out of 720 in a review of 407 Health Goods/ Services Purchase Authorization (407) forms in 2004	**Alberta:** • **More comprehensive than BC.** • Not provided explicitly, but may be provided through Assured Income for the Severely Handicapped as a Personal Benefit by request if it can be demonstrated it helps the client manage their disability. **Ontario:** • **More comprehensive than BC.** • Not explicitly provided. • However, may be provided through Ontario Disability Supports Program as a health-related discretionary benefit if it is related to the health of a client or member of the client's family.
Contraceptive Devices	• Considered a duplication of services	• **None.** Contraceptives are widely available through the provincial health care system (e.g. Pharmacare and family planning clinics)	**Alberta:** • **Comparable to BC.** • Birth control pills and patch are provided as a Health Benefit. • Intrauterine devices or intrauterine contraceptive devices are not covered. Requests for these items are reviewed on a case by case basis, as

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • **Alberta Aids to Daily Living Program (Community Supports Ministry)** • **Ontario Assistive Device Program (Health Ministry)**
			exceptions. **Ontario:** • **More comprehensive than BC.** • Birth control pills are available to IA clients through the Ministry of Health. • Other contraceptive devices and supplies may be provided as a health-related discretionary benefit under Ontario Works.
Diabetic Supplies and Equipment • Glucometers (testing machines) • Sharps containers for needle disposal	• Glucometers are available free from companies that provide test strips. • Lancets are provided by the Ministry. • Test strips are funded by the Ministry of Health.	• **None.** Clients will still be able to receive necessary equipment and supplies. o **Note:** Clients with a visual impairment require voice talking glucometers. These are not provided free of charge by test-strip companies. In these situations, the Ministry will provide the appropriate glucometers. (Note: this is not yet in OLR)	**Alberta:** • **Comparable to BC.** • Glucometers are provided as a one-time only benefit to a maximum of $70. • Lancets and test strips are provided. **Ontario:** • **Comparable to BC.** • Provide syringes, glucometers (partially funded by the Canadian Diabetes Association), test strips, and lancets. In Ontario the Canadian Diabetic Association provides coverage of diabetic supplies by administering the Ontario Monitoring Health program for the Ministry of Health and Long-Term Care. PWD clients are advised to contact the CDA first to receive funding.
Electrotherapy • basic TENS unit • gels • electrodes or accessories	• Available through the provincial health care system if required as part of physiotherapy treatment. • Eliminates duplication.	• **Minimal.** Clients with a demonstrated need for electrotherapy equipment will be able to access alternative treatments through the health care system (e.g. physiotherapy).	**Alberta:** • **More comprehensive than BC.** • Not provided explicitly, but may be provided through Assured Income for the Severely Handicapped as a Personal Benefit by request if it can be demonstrated it helps the client manage their disability.

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
			Ontario: • **More comprehensive than BC.** • Not explicitly provided, but may be provided through Ontario Disability Support Program as a health-related discretionary benefit under Ontario Works.
Vaporizers and Humidifiers	• Not medically essential	• **Minimal.** Anecdotally, the ministry received very few requests for these items.	**Alberta:** • **Comparable to BC.** • Not provided.
Apnea monitor	• Positive airway pressure devices are already provided • Eliminates duplication. • Not medically essential (BC MOH website states apnea monitors have not been shown to prevent Sudden Infant Death Syndrome (SIDS).	• **Minimal.** Anecdotally, the ministry received very few requests for these items.	**Alberta:** • **Comparable to BC.** • Not provided, except to infants at risk of SIDS. **Ontario:** • **More comprehensive than BC.** • Apnea and heart rate monitors are provided, but are rented only.
Medication Delivery Devices • Aerochamber	• Available through the provincial health care system • Eliminates duplication.	• **Minimal.** Aerochambers are available through the health care system (.e.g. hospital emergency, asthma clinics) s.13	**Alberta:** • **More comprehensive than BC.** • Provide nebulizers. • Aerochambers available as a Personal Benefit by request. Must demonstrate need. **Ontario:** • **More comprehensive than BC.**

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
			• Provide compressors/nebulizers. • Aerochambers not provided.
Alternative Positioning Devices	• Not medically essential as these items are secondary devices.	• **Minimal.** The ministry is meeting medically essential needs with the provision of a primary device.	**Alberta:** **Ontario:**

<table>
<tr><th>Previous Policy</th><th>Changes made April 2010</th><th>Rationale</th></tr>
<tr>
<td>

MSO clients had access to health supplements indefinitely as long they were B.C. residents.
No income testing or review for any client group

</td>
<td>

Continued access to health supplements for former clients will depend on individual circumstances, including income - see chart below.
Previously, these former clients had access to health supplements indefinitely as long they were BC residents.
Former BCEA clients who no longer meet the eligibility criteria for MSO will receive one-year transitional coverage.

<table>
<tr><th>Client Type</th><th>Reason for Leaving Assistance</th><th>Eligibility Criteria</th></tr>
<tr><td>PWD and PPMB</td><td>Federal Benefits</td><td>• Clients over 65 as long as they meet GIS income test.
• Clients transitioning to CPPD as long as they meet the CPPD income test.</td></tr>
<tr><td>PWD</td><td>Employment Income</td><td>• As long as they are eligible for MSP Premium Assistance</td></tr>
<tr><td>All client types</td><td>Crime Victims Assistance (SG)</td><td>• As long as they are eligible for MSP Premium Assistance</td></tr>
<tr><td>PWD</td><td>Agreement with Young Adults (MCFD)</td><td>• For the term of their agreement</td></tr>
</table>
</td>
<td>

Access to health supplements for former clients will be based on individual circumstances that include income levels.
The introduction of income testing to confirm ongoing eligibility ensures that supplements are provided only to those most in need.
Incentivizes employment by allowing clients to retain access to health supplements when they transition to employment.
Allows clients to take advantage of personal and professional development opportunities without requiring clients to forfeit access to health supplements
Income testing based on MSP premium assistance and/or GIS eligibility aligns with current low income tests used in existing government programs.

<u>Client Impacts:</u>

❖ Clients accessing income sources over the low income tests will become ineligible.
❖ Clients who are no longer eligible will receive one-year transitional coverage.

</td>
</tr>
</table>

Orthoses Items Still Provided

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Custom made foot orthotics	Only when failure to provide the custom-made foot orthotic is likely to result in partial or complete amputation of the foot $375 cost limit per pair 4 year replacement period	Ensures those persons most in need (e.g., diabetics with circulation problems) receive custom foot orthotics to prevent foot ulcers and subsequent amputation. Limits determined based on • research of the actual costs of equipment available; and • jurisdictional scan of best practices (Pedorthic Association of Canada Pricing Guidelines) Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Significant.** Clients are used to getting foot orthotics for mild/moderate conditions. New criteria intended to provide custom foot orthotics to clients with severe medical situations only.	**Alberta:** • **Less comprehensive than BC** • Item not provided **Ontario:** • **Less comprehensive than BC** • Item not provided
Custom made footwear	$1,650 cost limit per pair 1 year replacement period	Limits determined based on • research of the actual costs of equipment available; and • jurisdictional scan of best practices (Pedorthic Association of Canada Pricing Guidelines) Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal.** Custom made shoes are still provided.	**Alberta:** • **Comparable to BC** **Ontario:** • **Less comprehensive to BC** • Does not fund custom made shoes and no off the shelf items are provided. **Note:** PharmaCare does not provide custom made foot orthotics under their orthosis program for children

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Footwear modifications	1 year replacement period	Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Less comprehensive to BC** • Item not provided
Ankle brace	2 year replacement period	Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only
Ankle foot orthosis	2 year replacement period	Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only
Knee ankle foot orthosis	2 year replacement period	Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only
Knee brace	Must be worn at least 6 hours per day 4 year replacement period	Introduces a medical needs test to ensure supplement provided for intended target group. Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Moderate.** Knee braces now only considered for full time use.	**Alberta:** • **Comparable to BC** • Similar requirement that it must be for full time use (6 hours per day minimum) **Ontario:** • **Comparable to BC** • Custom items only • No full time requirement.
Hip brace	2 year replacement	Replacement periods are consistent with other	**Alberta:**

Specified Items	April 1, 2010 Policy Changes	Rationale	Cross Jurisdictional Comparison • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
	period	jurisdictions and private insurance **Impact on Clients:** • **Minimal**	• **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only
Upper extremity brace	2 year replacement period	Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only
Cranial helmet	Must be for daily use in cases of self abusive behaviour, seizure disorder, or to protect or facilitate healing of chronic wounds or cranial defects 2 year replacement period	Aligns regulation with current policy Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only
Torso or spine brace	2 year replacement period	Replacement periods are consistent with other jurisdictions and private insurance **Impact on Clients:** • **Minimal**	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Custom items only

Orthoses (Orthotics and Bracing)

Issues Identified:

- There were no controls in place to manage high cost items such as custom foot orthotics and custom footwear
- There was no guidance on what can be requested as an "orthotic or brace"
- Foot orthotics were provided to clients without "severe" foot conditions
- Procedural inefficiencies existed as the request form does not originate from the ministry
- Podiatrists, Occupational Therapists, and Physical Therapists could prescribe, assess, and fabricate items

Previous Policy	Changes Made April 2010	Rationale
• Ministry provided funding for orthotics and bracing to specific clients who have no other resources to pay for these items. • Medically essential for basic mobility • Required for one or more of the following: ❖ Prevent surgery ❖ Post surgical care ❖ Assist in physical healing from surgery, injury or disease ❖ Improve physical functioning that has been impaired by neuro-musculo-skeletal condition **Information:** Orthoses are items that are applied externally to the limb or body to provide support, protection or replacement of lost function. They are also commonly known as an orthosis, orthotic, brace, or splint.	**Must be Least Expensive:** • The item must be the least expensive that is appropriate for the purpose.	• Intent focuses on providing the least expensive orthoses to meet a medically essential need
	Types of Items Covered are Specified: • Introduced revised eligibility criteria specifying the types of items that may be considered. • Some items that no longer covered include off the shelf shoes and off the shelf foot orthotics • Custom made foot orthotics are now only considered where failure to provide is likely to result in partial or complete amputation of the foot	• Clients, health professionals, advocates, and staff have a clearer understanding of items available and what criteria are required • Aligns regulations with longstanding policies for specified items as well as some items we have never covered - not considered as an orthotics under ministry policy (e.g., orthosis for sports) • Off the shelf shoes are not considered medically essential • Foot orthotics can be seen as beneficial for almost anyone but the majority of these are not medically essential • Custom foot orthotics will be provided to people with the most severe medical situations Client Impact: • Approx 800 clients received off-the-shelf shoes in 2009 • Approx 1500 clients received foot orthotics for non-severe medical conditions in 2009 • 1800 in total received foot orthotics in 2009
	Revised and Additional Eligibility Criteria • Medically essential to achieve or maintain basic functionality • A medical/nurse practitioner now must confirm that a knee brace must be required for at least 6 hours per day • A medical/nurse practitioner now must prescribe	• Using functionality rather than mobility is more relevant to all types of orthoses (e.g., braces or splints not necessarily required for mobility) • 6 hour knee brace requirement based on jurisdictional scan of best practices (Alberta Aids to Daily Living, BC Pharmacare) • Medical/nurse practitioner prescription required for

	all items and confirm if custom made is required	all requests to ensure items are medically required. <u>Client Impact</u>: • Minimal (unable to determine)
	Replacement Criteria Established: • Replacement criteria moved from policy to regulations.	• Ensures clients and staff have full information about replacement periods. • Equipment replacement periods are consistent with other jurisdictions and private insurance (e.g. federal government's non-insured health benefits)
	Funding Limits Established: • Custom made foot orthotics: $375 • Custom made footwear: $1650 • These limits include assessment fees	• Prevents requests for non-basic, high-end items. • Limits determined based on research of the actual costs of equipment available. • Funding limits based on jurisdictional scan of best practices (Pedorthic Association of Canada Pricing Guidelines) and actual costs of items
	Nurse Practitioners can now prescribe items	• Aligns with recent changes to Health Professions Act (within scope of practice) • Increases accessibility for clients
	Guidelines to Staff: • Guidelines provided to ministry staff on the following terminology: basic functionality and no other resources	• Outline factors considered by the ministry when determining if orthoses requests are medically essential to achieve or maintain basic functionality. • Practice standards outlined in policy • Clients, health professionals, advocates, have a clearer understanding of what factors are used when determining eligibility

	Revised Application Process
	• Redesigned application form and procedural changes where the application form no longer originates at the supplier. The form now initiates at ministry office rather than health professional
	• The orthoses request form now asks the medical/nurse practitioner 4 questions (previously, the medical practitioner provided a prescription):
	  ○ Describe the medical condition
	  ○ Type of orthosis recommended
	  ○ Is a custom made orthosis required?
	  ○ If a knee brace, required at least 6 hours per day?
		• Supports evidence-based decision making
		• Staff have better information to make the correct decision
		• Process now aligns with the medical equipment process for consistency

Orthoses Items No Longer Provided

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Prosthetic and related supplies	• Aligned regulations with longstanding policy	• **None.** PharmaCare provides extensive prosthesis program.	**Alberta:** • **Comparable to BC** • Item funded through Pharmacare in BC, not Social Development **Ontario:** • **Comparable to BC** • Item funded through Pharmacare in BC, not Social Development
Plaster or fiberglass cast	• Aligned regulations with longstanding policy	• **None.** Available through the provincial health care system.	**Alberta:** **Ontario:**
Hernia support	• Aligned regulations with longstanding policy	• **Minimal.** Alternate treatment options available through the provincial health care system	**Alberta:** **Ontario:** • **Comparable to BC** • Only custom items provided
Abdominal support	• Aligned regulations with longstanding policy	• **Minimal.** Alternate treatment options available through the provincial health care system	**Alberta:** **Ontario:**
Walking boot for a fracture	• Aligned regulations with longstanding policy	• **Minimal.** Alternate treatment options available through the provincial health care system	**Alberta:** **Ontario:**
Orthoses item primarily for recreation or sports	• Aligned regulations with longstanding policy • Not considered medically essential to achieve or maintain basic functionality	• **Minimal.** Orthoses for basic functionality are provided.	**Alberta:** • **Comparable to BC** **Ontario:** • **Comparable to BC** • Items funded for “basic needs”

Specified Items	Rationale	Impact on Clients	Cross Jurisdictional Comparison: • Alberta Aids to Daily Living Program (Community Supports Ministry) • Ontario Assistive Device Program (Health Ministry)
Prefabricated foot orthotics (not explicit in regulation but excluded due to not being included in the definition of "orthoses")	• Foot orthotics can be seen as beneficial for almost anyone but the majority of these are not medically essential	• **Moderate.** Custom foot orthotics are provided to people with the most severe medical situations.	**Alberta:** • **Comparable to BC** • Item not provided **Ontario:** • **Comparable to BC** • Item not provided **Note:** PharmaCare also does not provide under their orthosis program for children
Off the Shelf Shoes (e.g. New Balance, Nike, Reebok, and "orthopaedic shoes) • Not explicit in regulation but excluded due to not being included in the definition of "orthoses"	• Off the shelf shoes are not considered medically essential • Currently off the shelf shoes are provided for clients that need accommodation for foot orthotics – these types of shoes are not an "orthotic" or "brace" but rather a clothing item	• **Moderate.** Custom made shoes are provided to people with the most severe medical situations.	**Alberta:** • **More comprehensive than BC** • Does provide "orthopaedic" type off the shelf shoes **Ontario**: • **Comparable to BC** • Does not provide any off the shelf shoes

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

COPY

DATE: July 7, 2009

PREPARED FOR: Cairine MacDonald- Deputy Minister

ISSUE: Elimination of the minimum $75 shelter allowance

BACKGROUND:

Currently, the following family units are eligible for a minimum shelter allowance of $75 for each eligible person:

- persons aged 60-64 who are not eligible for the federal spouse's allowance but are eligible for income assistance, or
- an applicant or recipient of the family unit is a person with disabilities.

The individuals receiving the minimum $75 shelter allowance have no or little shelter costs. All other client groups must prove they have shelter expenses in order to receive the shelter allowance.

This minimum shelter allowance of $75 has been in place since 1973. Originally it was part of the *Mincome* program under the *Social Services Act*. At that time the monthly shelter rate for a single person was $75, therefore *Mincome* was a form of flat rate for entitled groups (seniors, 60-64 year olds and the disabled).

Subsequent increases to shelter rates were not added to the minimum and thus the $75 amount remained static. Under the *Guaranteed Available Income for Need (GAIN) Act* the amount of $75 was guaranteed as a minimum shelter amount. This continued unchanged under the *BC Benefits Income Assistance and Youth Works Acts* and the *BC Employment and Assistance Act*. Regulatory authority is found in Schedule A of the current and former legislation.

DISCUSSION:

This special allowance has been paid for over 35 years and the original purpose and intent of a flat rate minimum shelter allowance no longer applies.

Within the current income assistance framework, it now seems arbitrary as it is applied to only 60-64 year olds and PWD's. The 60-64 year olds are no longer the distinct category of clients they once were in terms of allowances or programs, with the exception of the Bus Pass Program. PWD's are a distinct group in many respects and

receive a much higher support allowance than others, but receive the same amounts for shelter as all other categories and require the same proof for shelter expenses except for the minimum allowance.

Of those clients currently in receipt of the $75 allowance, there are two general categories: those living in cost-free accommodations and homeless individuals (Appendix A: Table 1 Living Arrangements). For those who are living in accommodations cost free, the impact would be minimal, but may result in new costs being claimed. For homeless clients, eliminating this allowance takes cash off the streets and encourages them to find suitable accommodation. If required, minimum income assistance can be applied to the support allowance without the necessity of adding an arbitrary shelter component.

Currently, fewer than 40 clients age 60-64 years and 1,200 PWD's receive this minimum allowance (Appendix A: Table 2 Number of Clients). Not Responsive
(Appendix A: Table 3 Costing).

Implementation would require regulatory changes and could be done as soon as a Cabinet date was available for Order in Council. Systems changes are required, taking four to eight weeks and costing $5,600 - $8,000. The target date would be Not Responsive
Notification to staff and clients would be appropriate at least one month in advance.

OPTIONS:

1. ***Status quo.***

Implications:

- Continuation of a program and expenditures that has no justification in the current income assistance model;
- No negative attention from advocates and the media.

2. **Eliminate the minimum shelter allowance for 60-64 year olds and PWD's effective** Not Responsive

Implications:

- s.13
- Provides consistent and accountable policy regarding shelter payments to all clients;
- Can be seen as an incentive to improve the lives of homeless clients;
- Clients living in cost free accommodation may develop new costs, thus impacting projected savings;
- May result in a negative response from advocates and media.

MINISTRY OF HOUSING AND SOCIAL DEVELOPMENT
DECISION NOTE

RECOMMENDATION:

2. **Eliminate the minimum shelter allowance for 60-64 year olds and PWD's effective** s.13

Approved/~~Not Approved~~ Date:

Cairine MacDonald — Aug 20/09

Cairine MacDonald
Deputy Minister

PREPARED BY:
Bob MacFarlane
Policy Analyst
250 356 1887

REVIEWED BY (pls initial): **DATE:**
Ann Chatwin — Aug 05/09
A/Director
Strategic Policy and Research Branch

Rob Bruce — Aug 5/09
Executive Director
Strategic Policy and Research Branch

Molly Harrington — Aug 6/09
Assistant Deputy Minister
Policy and Research Division

Table 1: Living Arrangements

Year/Month	Homeless	Total	% Homeless
200807	461	1,242	37%
200808	473	1,269	37%
200809	471	1,284	37%
200810	473	1,304	36%
200811	463	1,294	36%
200812	432	1,226	35%
200901	436	1,259	35%
200902	394	1,232	32%
200903	385	1,189	32%
200904	395	1,198	33%
200905	337	1,214	28%
200906	329	1,201	27%
Average	**421**	**1,243**	**34%**

Table 2: Number of Clients Receiving $75 Shelter Minimum Allowance July 2008 to June 2009

Year/Month	PWD	Age 60-64	Exceptions*	Total
200807	1,205	33	4	1,242
200808	1,236	30	3	1,269
200809	1,252	28	4	1,284
200810	1,270	32	2	1,304
200811	1,259	31	4	1,294
200812	1,188	33	5	1,226
200901	1,223	31	5	1,259
200902	1,193	37	2	1,232
200903	1,147	36	6	1,189
200904	1,152	37	9	1,198
200905	1,170	41	3	1,214
200906	1,152	42	7	1,201
Average	**1,204**	**34**	**5**	**1,243**

*For example, there are cases of individuals with various temporary status'.

Table 3: Costing

Not Responsive

**Table 1: Clients Receiving $75 Shelter Minimum
June 2008 to May 2009**

Year/Month	PWD	Age 60-64	Total
200806	1,136	33	1,169
200807	1,205	33	1,238
200808	1,236	30	1,266
200809	1,252	28	1,280
200810	1,270	32	1,302
200811	1,259	31	1,290
200812	1,188	33	1,221
200901	1,223	31	1,254
200902	1,193	37	1,230
200903	1,147	36	1,183
200904	1,152	37	1,189
200905	1,170	41	1,211
Average	**1,203**	**34**	**1,236**

Table 2: Costing

Not Responsive