Out-of-Province Medical Claims Program

SEPTEMBER 2026

REPORT OF THE AUDITOR GENERAL TO
THE NOVA SCOTIA HOUSE OF ASSEMBLY

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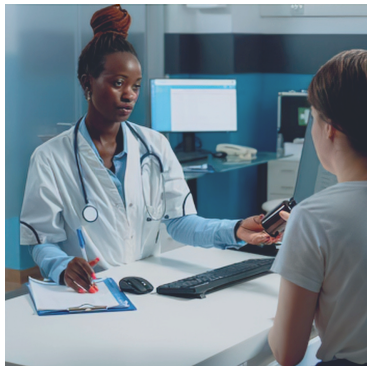

September 15, 2026

Honourable Danielle Barkhouse
Speaker
House of Assembly
Province of Nova Scotia

Dear Madam Speaker:

I have the honour to submit herewith my Report to the House of Assembly under Section 18(2) of the *Auditor General Act*, to be laid before the House in accordance with Section 18(4) of the *Auditor General Act*.

Respectfully,

Kim Adair, FCPA, FCA, ICD.D
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Department of Health and Wellness

Out-of-Province Medical Claims Program

Why We Did This Audit

- The out-of-province and out-of-country medical claims program is vital for ensuring access to medically necessary care not available in the province
- A judicial review found two individuals had been unfairly rejected in their request for coverage
- The Premier requested our Office review and assess the program on its human-centred approach

Key Audit Results

Our audit found about 90% of patients applying for out-of-province medically necessary care are approved. However, patients without in-province specialists still face an unclear and difficult pathway to access care

Oversight of the Program Administrator is inefficient and unclear

- Duplication of review efforts by the Department and the Program Administrator has slowed response times and is not cost-effective

The Department did not have a human-centred approach to review applications

- Human-centred guidance remains limited in policy, despite some tone and language improvement in applicant responses

Appeals process lacks clear policy direction and decision-maker independence

Information regarding the program is not readily available to the public and physicians

This report makes

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to strengthen the out-of-province and out-of-country medical claims program.

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Recommendations and Responses

Recommendation	Department Response
Recommendation 1 We recommend the Department of Health and Wellness identify cases where no appropriate Nova Scotia specialist exists and establish and implement an alternative pathway for these patients to have their eligibility assessed. *See paragraph 41*	Department agrees **Target Date for Implementation**: September 2027 **Department Response to Recommendation 1** The Department agrees with the recommendation's objective of ensuring a clear and consistent approach for patients whose circumstances may involve limited or unavailable specialist expertise in Nova Scotia. The Department recognizes that rare, complex, or emerging conditions can present challenges in accessing appropriate specialist assessment and will strengthen existing processes to identify these cases and support patients in accessing the specialist expertise required to evaluate their condition and, where clinically appropriate, support an application for out-of-province or out-of-country services. The Department will address these circumstances within existing program processes and does not support establishing a separate eligibility pathway. A referral from a qualified specialist remains an essential safeguard to confirm medical necessity, ensure appropriate clinical oversight, consider available treatment options, support continuity of care, and promote responsible stewardship of public resources. This approach is consistent with existing legislative and policy requirements and reflects standard referral-based assessment practices across Canadian jurisdictions.
Recommendation 2 We recommend the Department of Health and Wellness establish and apply criteria defining a standard application and determine when additional Departmental review of applications and appeals should occur. *See paragraph 48*	Department agrees **Target Date for Implementation**: September 2028 **Department Response to Recommendation 2** The Department agrees with the recommendation to strengthen criteria defining standard applications and clarify when additional Departmental review should occur. Existing policies outline application requirements; however, they do not provide sufficient detail to consistently distinguish routine cases from those requiring escalation. The Department also notes that current policies do not explicitly set expectations for a human-centered approach, although Departmental oversight has supported more consistent and personalized communication while broader policy updates are underway. The Department will establish criteria to distinguish standard applications from cases requiring additional review and define clear escalation thresholds for complex, non-routine, or precedent-setting matters. The updated approach will support effective oversight, reduce unnecessary duplication, improve

Recommendation	Department Response
	consistency in decision-making, and promote timely processing while maintaining appropriate safeguards and accountability.
Recommendation 3 We recommend the Department of Health and Wellness require the Program Administrator to: • Collect program data using standard medical diagnoses for applications and appeals; and • Regularly analyze this information to identify trends including recurring conditions and cases where no Nova Scotia specialist exists. *See paragraph 51*	Department agrees **Target Date for Implementation**: September 2027 **Department Response to Recommendation 3** The Department agrees that the Program Administrator should implement standardized diagnostic coding to support consistent data collection, reporting, and analysis. While clinical terminology currently varies depending on data entry practices, applications can generally be reviewed and categorized appropriately; however, greater standardization will improve data quality, reliability, and usability. The Department also agrees that regular analysis of standardized data would strengthen oversight of Program utilization and support identification of recurring conditions, emerging trends, and circumstances where specialist expertise may not be available within Nova Scotia. The Department will work with the Program Administrator to implement standardized diagnostic coding and establish regular monitoring and reporting of program activity, including applications, approvals, denials, appeals, and inquiries. Over time, this information may support broader health system planning and assist in identifying areas requiring additional specialist capacity.
Recommendation 4 We recommend the Department of Health and Wellness strengthen oversight of the Program by: • Establishing performance measures, including response time standards; • Monitoring and reporting on performance against these measures; and • Establishing and implementing a process for corrective action where service standards are not achieved. *See paragraph 58*	Department agrees **Target Date for Implementation**: September 2027 **Department Response to Recommendation 4** The Department agrees with the recommendation to strengthen oversight through performance measures, response time standards, regular monitoring, and corrective action processes where required. The Department recognizes that response times can vary depending on application complexity, completeness of information, and the need for additional clinical or administrative review. While some applications may require additional assessment, applicants should receive timely communication regarding the status of their request. The Department will establish performance measures and reporting processes, including monitoring against response time standards, and will review performance on a regular basis. Interim communication expectations will also be

Recommendation	Department Response
	formalized for files requiring additional review beyond established service standards. The Department will work with the Program Administrator to implement these measures, identify service gaps, and establish corrective actions where performance expectations are not met.
Recommendation 5 We recommend the Department of Health and Wellness update the out-of-province and out-of-country medical claims policies to include a human-centred approach throughout the review, decision-making, and communication processes. *See paragraph 69*	Department agrees **Target Date for Implementation**: September 2028 **Department Response to Recommendation 5** The Department agrees that the out-of-province and out-of-country medical claims policies should be updated to further reflect a human-centred (patient-centred) approach to assessment, adjudication, and communication. Historically, communications were primarily intended for physician-to-physician communication between the referring specialist and the Medical Consultant. As a result, correspondence often reflected a direct and matter-of-fact style rather than a human-centred approach. The Department acknowledges that these communications may also be shared with patients and would benefit from clearer, more patient-centred language and explanations. Since November 2024, Departmental oversight of decision letters has improved consistency in tone and language. The Department will update policies to incorporate human-centred communication principles, clarify expectations, and ensure all relevant reasons for decisions are communicated consistently and transparently.
Recommendation 6 We recommend the Department of Health and Wellness improve and clarify guidance to the Program Administrator for the out-of-province and out-of-country program, including guidance for: • Application documentation; • Tools to assess applications and appeals; and • Requirements for communications with applicants, including approvals, denials, and appeals. *See paragraph 83*	Department agrees **Target Date for Implementation**: September 2027 **Department Response to Recommendation 6** The Department agrees that additional procedural guidance is required to support consistent application assessment, appeals processing, decision-making, and communication practices. The Department will work with the Program Administrator to establish and document detailed procedures aligned with current policies and program eligibility criteria. This work will include clarification of documentation requirements, assessment processes, standardized tools, and communication expectations for approvals, denials, and appeals.

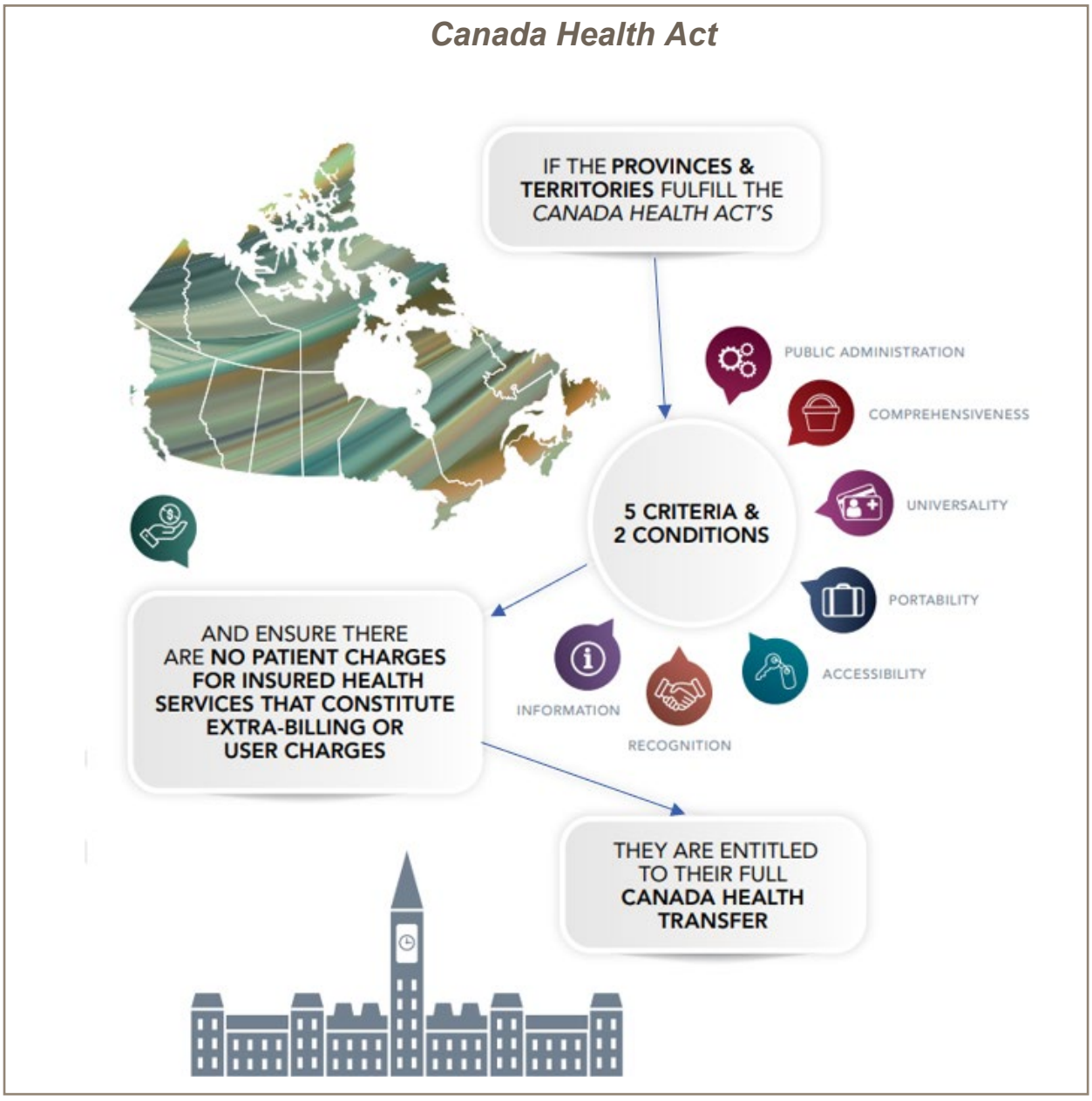
Recommendation	Department Response
	The Department will also support the review and refinement of assessment tools used by the Program Administrator, including checklists and decision-support resources used by the Medical Consultant, to promote consistency and transparency. While Department policies provide overall program direction, the Department agrees that operational procedures should more clearly align with policy requirements and reinforce expectations regarding documentation, standardized assessment practices, and human-centered communication.
Recommendation 7 We recommend the Department of Health and Wellness establish a clearly communicated appeals process which: • Requires appeals to be reviewed by a qualified individual with appropriate medical expertise; • Prohibits the original decision-maker from reviewing their own decision; • Defines documentation requirements, including completion of standardized review tools; • Provides guidance on communicating appeal decisions using a human-centred approach; and • Is publicly available to physician applicants and patients. *See paragraph 93*	Department agrees **Target Date for Implementation**: September 2028 **Department Response to Recommendation 7** The Department agrees that the appeals process requires clearer policy direction, documentation requirements, public transparency, and defined review responsibilities. In practice, appeals are accepted from the referring provider, patient, or an individual authorized by the patient. The Department agrees that policies should be updated to accurately reflect established practice and ensure there are no unnecessary administrative barriers to submitting appeals. Under the Administration Services Agreement, appeal reviews currently involve the Medical Consultant, who provides the clinical expertise required to support review of clinical information. The Department will update policies to clearly document review responsibilities, establish independence requirements so that original decision-makers do not review their own decisions, and ensure procedural and public-facing materials consistently reflect these requirements. The Department will also support development and implementation of standardized review tools and ensure public-facing information reflects the updated appeals process.
Recommendation 8 We recommend the Department of Health and Wellness publish easily accessible, clear, plain-language guidance for physician applicants and patients aligned with program practices and policies, including: • application requirements; • required documentation; and • response time standards.	Department agrees **Target Date for Implementation**: Completed (March 2026) **Department Response to Recommendation 8** The Department agrees with the recommendation to provide clear, plain-language public guidance on application requirements, documentation requirements, and service standards.

Recommendation	Department Response
See paragraph 106	This issue had already been identified by the Department and addressed through the launch of a new public website that consolidates relevant program information previously available primarily through the MSI Physician Bulletin. Information is now accessible in plain language for both Nova Scotians and health care providers through a more user-friendly and accessible platform. The website includes information on eligibility requirements, application processes, required documentation, appeals, and expected response time standards, including how applicants will be informed of decisions. This improvement enhances transparency, supports submission of more complete applications, and promotes greater consistency in program administration.

Background

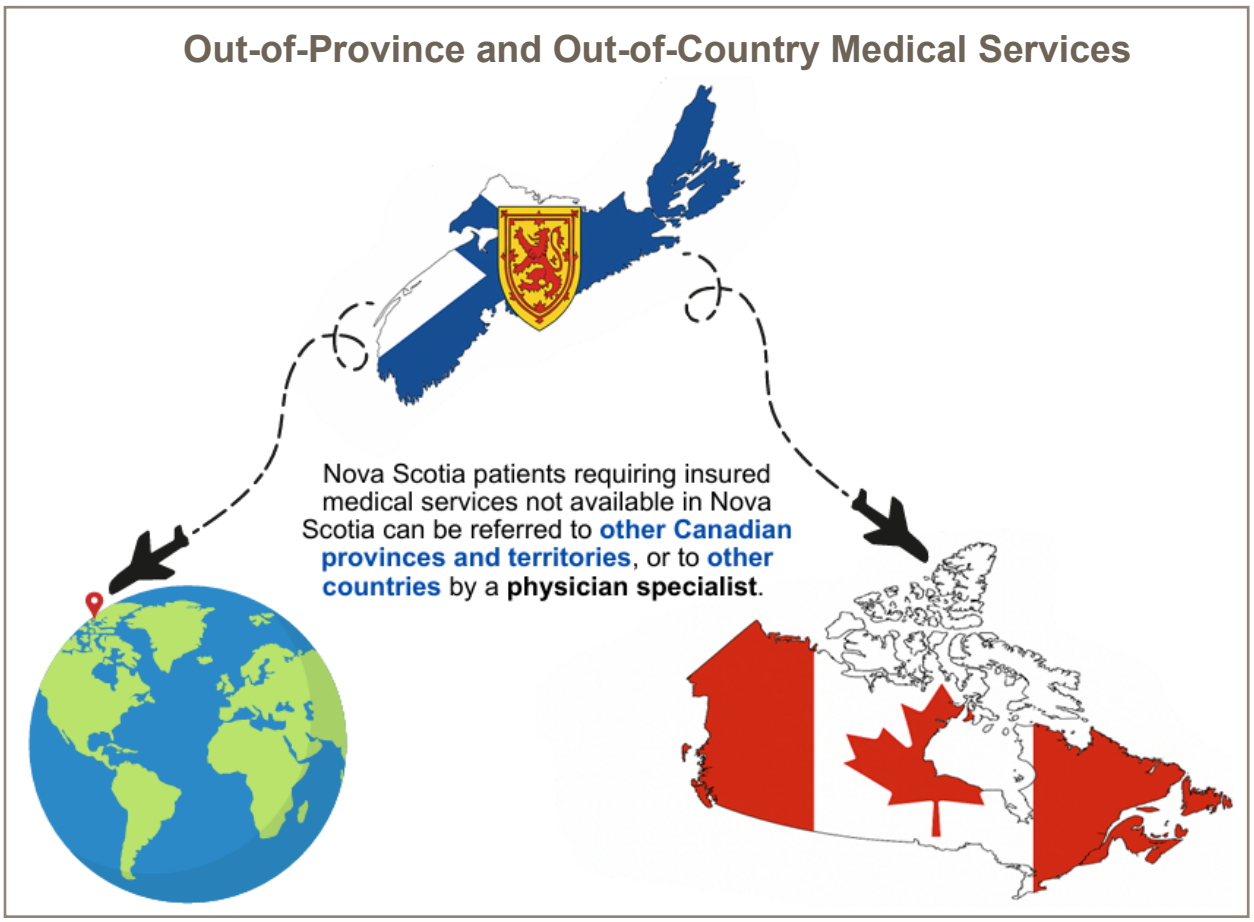
Out-of-province and out-of-country medical claims program

1. Under the *Canada Health Act*, provinces and territories in Canada must ensure that all eligible residents have access to insured health services to receive federal cash contributions.



Source: Office of the Auditor General of Nova Scotia with Information from Canada Health Act

2. When these medically necessary services are not available in a patient's home province or within Canada, there are options for patients to apply to receive healthcare elsewhere.



Source: Office of the Auditor General of Nova Scotia

3. Many out-of-province medical services are billed between Canadian provinces through a reciprocal billing agreement. For out-of-country medical services and certain out-of-province medical services, the provinces and territories commit to pay for the service through a pre-approval process. This report will refer to applying for pre-approval for either the out-of-province or out-of-country medical claims as the "Program."

4. The Department of Health and Wellness (the 'Department') does not maintain a complete public facing list of insured services of the Nova Scotia Health Insurance Program. Instead, most insured services, including in-patient and out-patient services to which a resident is entitled, are defined by the *Health Services and Insurance Act*, the Interprovincial Reciprocal Billing Agreements, and the Physician Manual.

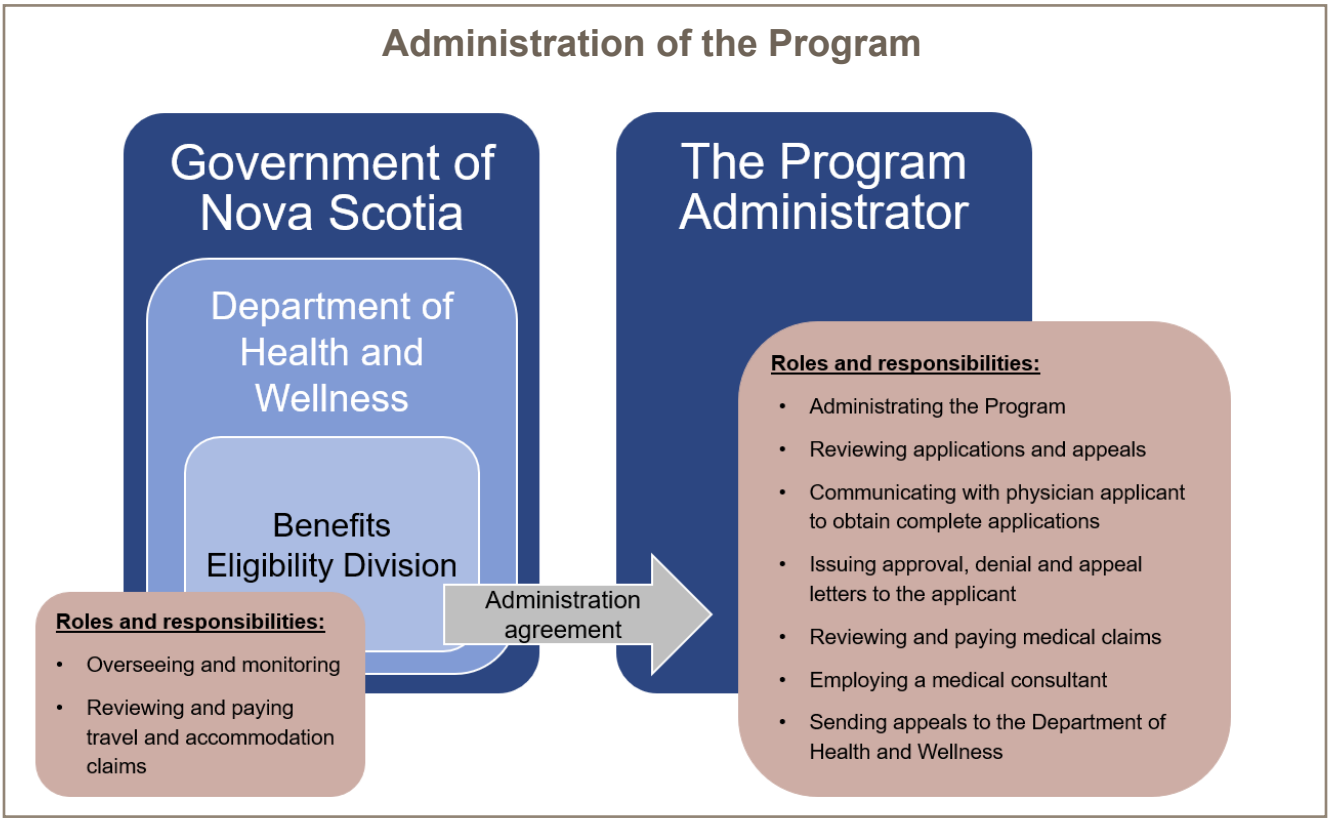
5. In Nova Scotia, some examples of diagnoses that have resulted in out-of-province or out-of-country referrals are gender dysphoria, lung transplants, lymphedema and ocular melanomas.

Administrating the program

6. In Nova Scotia, payment of out-of-province and out-of-country medical claims is governed by the Hospital Insurance Regulations under the *Health Services and Insurance Act.* The Benefit Eligibility division of the Department is responsible for considering applications to the Program as part of the benefits under the Nova Scotia Health Insurance Program.

7. Through an Administration Services Agreement, the Department has contracted the responsibility for administering the Program to a third-party service provider (hereafter referred to as 'the Program Administrator'). The Program Administrator has managed the Program on behalf of the Department for over 20 years.

8. The Program Administrator told us they do not deliver a similar Program for any other Province or Territory; their administration of the Program is unique to Nova Scotia. Administration of the Program entails reviewing applications and appeals; communicating with the physician applicant to obtain all necessary information; issuing approval or denial letters; as well as reviewing and paying medical claims under the Program.



Source: Office of the Auditor General of Nova Scotia

9. Payments to the Program Administrator under the Administration Services Agreement include other programs that the Program Administrator delivers on behalf of the Province, such as Health Card Administration Services and Pharmacare. As these costs are not attributable solely to this Program, they are not presented in this report.

10. The Program's annual expenditures including hospital services, physician services, and travel and accommodation expenses, are presented in the table below. Administrative expenses and staff salaries are excluded, as these costs are shared across multiple program areas.

Total Annual Program Spending
(April 1, 2022 to March 31, 2026)

Fiscal year	Amount Spent
2022–23	$5,500,000
2023–24	$13,340,000
2024–25	$11,630,000
2025–26	$14,040,000
Four-year total	$44,510,000

Source: Department of Health and Wellness (unaudited)

Services outside the scope of the program

11. The Program supports Nova Scotians who are referred to receive insured health services outside the province when those services are not available within Nova Scotia.

12. The audit reviewed Program requests from referring physicians for pre-approval of referrals, to receive medically necessary services outside Nova Scotia or Canada, that were approved, denied and appeal of denials. Medical services received outside the province that were not pre-approved under the Program, such as emergency medical treatment required while travelling, fall outside the scope of the Program and were not included in the scope of this audit. The Department encourages Nova Scotians who travel to obtain medical travel insurance for costs not covered.

Program eligibility

13. To be eligible for the Program, the individual should:
- be legally entitled to remain in Canada;
- make Nova Scotia their primary home;
- be physically present in Nova Scotia for at least 183 days every calendar year; and
- not be a tourist, transient or visitor to Nova Scotia.

14. The *Health Services and Insurance Act* and regulations, along with internal policies of the Department, establish application requirements. In addition to the requirements below, Department policy also states the application should be submitted by a physician specialist registered with the College of Physicians and Surgeons of Nova Scotia and should be

involved in the care of the patient. Under the Program, the physician specialist is the applicant, applying on behalf of their patient.

Support Required to Apply to the Program

Support Required to Apply to the Program	*Out of Province	**Out of Country
A description of the patient's relevant medical history	✓	✓
A description of health services requested	✓	✓
Expected benefits to the patient	✓	✓
Any follow-up requirements	✓	✓
A written recommendation in support of the service by the specialist	✓	✓
Documentation of reputable clinical trials, published in peer reviews	✓	✓
Information of the availability in Nova Scotia and why they do not meet the patient's needs	✓	
A written recommendation of medical evidence that the resident needs an escort to travel	✓	
Information of the availability in Canada and why they do not meet the patient's needs		✓

*Out-of-province medical claims policy requirements
**Out-of-country medical claims policy requirements

Source: Office of the Auditor General of Nova Scotia

15. The Administration Services Agreement requires the Program Administrator to employ a medical consultant who reviews and approves all applications, assists with appeals, provides clarification when concerns arise with billings to physicians or facilities, and handles any other requests from the Department regarding the Program.

16. Once approval has been obtained for the medical service, the patient qualifies for travel and accommodation coverage through the Department to receive the out-of-province or out-of-country medical service. Travel and accommodation expenses are paid after the travel has

occurred and only for the actual amount expensed. If approved, applicants may receive assistance for:

- up to $600 one-way or $1,200 for round-trip travel by plane, train or bus;
- up to $600 one-way or $1,200 for round-trip travel by plane, train or bus for an approved travel companion;
- kilometrage per trip for travel by personal vehicle (amount is based on government regular kilometrage rate and most direct route between the Nova Scotia civic address and medical facility); or
- up to $230 per night (maximum $2,760 per trip) for short-term accommodation for the resident or up to $3,000 per month when approved to relocate for more than 30 days.

Program operations

17. The table below shows both approved, denied, and appealed applications over the last four years. In each of the last four years, the majority of applications were approved. Although a small number of decisions were appealed over the last four years, the majority were not overturned.

Program Statistics

Applications	2022-23	2023-24	2024-25	2025-26*	Total
# of Applications	454	444	415	356	1,669
# Approved	429 (94%)	396 (89%)	369 (89%)	350 (98%)	1,544 (93%)
# Denied	25 (6%)	48 (11%)	46 (11%)	6 (2%)	125 (7%)

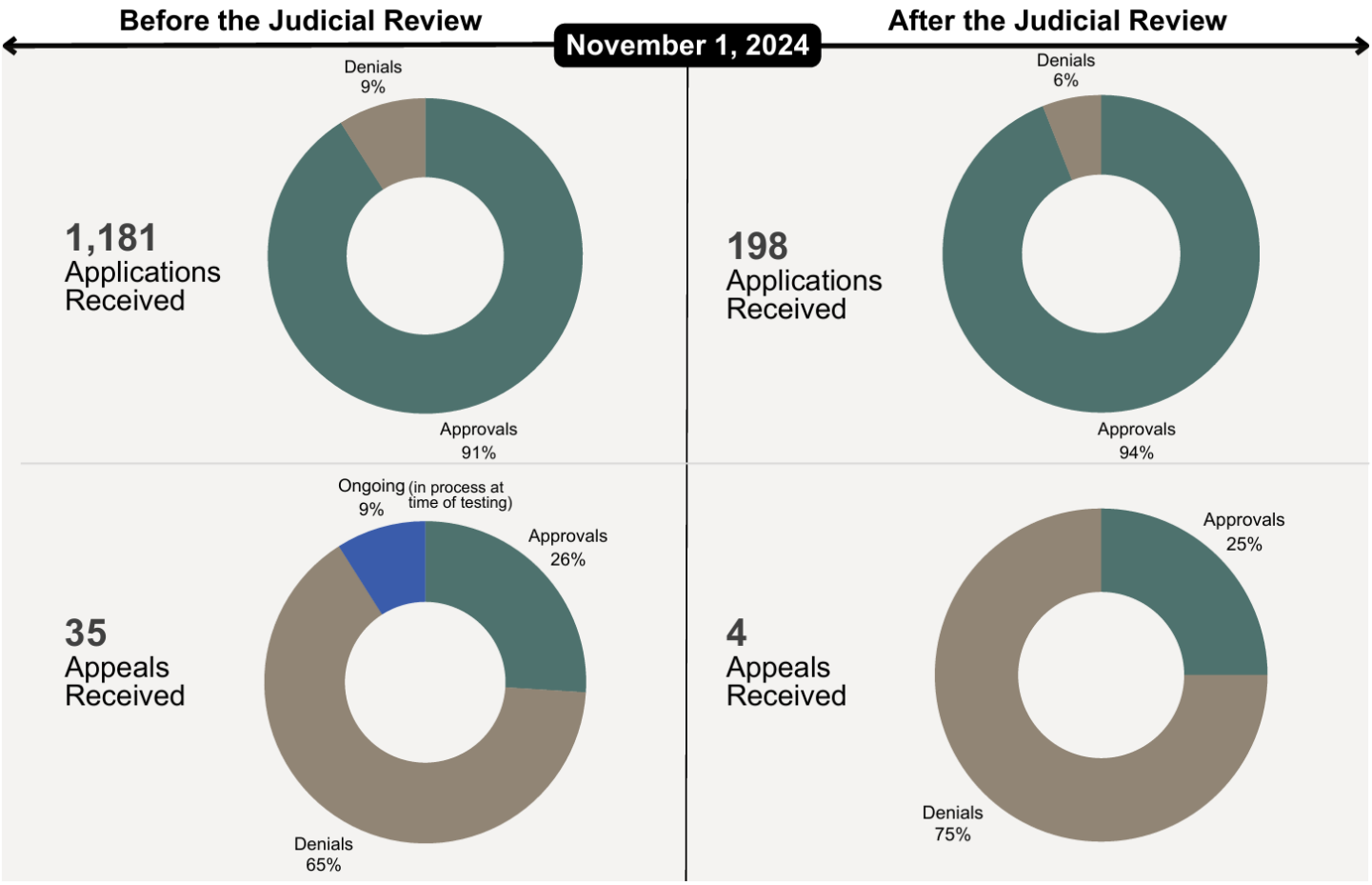
Appeals	2022-23	2023-24	2024-25	2025-26*	Total
# of Appeals	12	15	17	3	47
# of Appeals Approved	3 (25%)	5 (33%)	5 (29%)	0 (0%)	13 (28%)
# of Appeals Denied	9 (75%)	10 (67%)	12 (71%)	3 (100%)	34 (72%)

**Our audit testing examined information up to April 30, 2025. Data for 2025-26 has been added for informational purposes.*

Source: Table created by Office of the Auditor General of Nova Scotia; data provided by the Program Administrator - figures represent best approximation of out-of-province program activity by year.

18. We selected a sample from 1,379 applications and 39 appeals that occurred during our testing period of January 1, 2022 to April 30, 2025. Of the total applications, 94% were out-of-province medical claims, while about 6% were out-of-country medical claims. These applications can be broken down to fit in the before and after judicial review windows as follows:

Program Applications and Appeals Before and After the Judicial Review



Source: Office of the Auditor General of Nova Scotia

Judicial review

19. On October 31, 2024, the Supreme Court of Nova Scotia (the 'Court') ruled in favour of two Nova Scotian woman who applied for a judicial review of the Department's denial of their applications to the Program.

20. The Court found that the women were "discriminated against… on the basis of their rare medical condition" and that they had been "treated in a procedurally unfair manner."

21. After the Court's decision, the Premier of Nova Scotia apologized to the women and stated the Province would reimburse all travel, treatment and legal expenses including interest on

their expenses to date; and would cover further treatment deemed medically necessary to manage the ongoing condition of one of the individuals. We independently verified the individuals were compensated for expenses incurred prior to the judicial review.

22. Following the judicial review, the Department conducted internal reviews to identify Program improvements. Our audit refers to the period before the judicial review as ‘before November 2024’ and the period after the judicial review as ‘after November 2024’.

Human-centred approach

23. Our office was asked to conduct a performance audit of:

    a. the manner in which the Department of Health and Wellness handles Program applications and requests

    b. the circumstances that led to the two women launching the judicial review

    c. the entire out-of-province and out-of-country approval process to ensure that it meets the goal of being human-centred while ensuring the Program is being sufficiently and humanely rigorous about the evidence required to ensure the prudent use of public resources for medically required services.

24. A universal definition for ‘human-centred’ does not exist, therefore we considered multiple sources to define a ‘human-centred’ (or ‘patient-centred’) approach. These sources include discussions with the Department and the Program Administrator, guidance from the judicial review and court decision, and interpretations by organizations such as the World Health Organization and Mayo Clinic.

25. For this audit, a human-centred (or patient-centred) approach involves viewing each patient as a unique human being and assessing and formulating their health care around their unique needs. It involves being transparent, compassionate, and fair towards each patient and communicating relevant and accurate information to help patients navigate the healthcare system.

26. During our audit we have applied that human-centred lens to our testing and review. In practical examples of this definition, we would expect the Program to use 'human-centred language'; communicate with a respectful tone; provide clear messaging and actionable items; provide all reasons for denying an application; and personalize the responses to an individual patient’s needs.

The Department's Interim Changes Following the Judicial Review Did Not Resolve Barriers to Accessing Care

Patients without a recognized Nova Scotia specialist or required specialist services face a difficult and unclear pathway to access care

27. We obtained and reviewed the correspondence and documentation that preceded the judicial review. We identified a key factor for the two individuals: they were diagnosed with medical conditions requiring specialized care not available in Nova Scotia.

28. Under the Program's current requirements, applications must originate from a Nova Scotia specialist in the relevant condition. Where no such specialist exists in the province, or where specialists do not provide specialized services, individuals in need are unable to satisfy this requirement regardless of whether all other eligibility criteria are met.

29. The Program application history for one of the individuals dates back to June 2021, when they first applied requesting coverage from the Program. Since then, the individual submitted multiple applications which were denied, two of which the applicant subsequently appealed.

30. The individuals obtained referrals and supporting letters from several physicians and caregivers. However, none of the applications were accepted because the physicians were not recognized by the Program as specialists in the specific condition for which the individuals were seeking treatment.

31. In effect, the absence of a Nova Scotia specialist able to perform those services prevented the applicants from meeting the Program's requirements. In addition, the individuals had been provided with inaccurate guidance on how to navigate the system by the Program Administrator, including incorrect information about specialist availability in the Province.

32. In addition to the eligibility barrier, we observed weaknesses in the administration of the individual's file, including delays in responses to inquiries; use of non-human-centred language in correspondence; and denial letters that did not clearly outline all reasons for refusal. These issues are discussed later in this report.

33. It is reasonable to expect that patients with rare, complex, or emerging conditions, particularly where local expertise is unavailable, will seek access to this Program, as it may represent their only avenue to obtain specialized care in other provinces or countries. In such cases, the Program's design creates a structural barrier to access.

34. Following the judicial review, the Department implemented interim process changes, such as additional review steps for applications. However, these changes did not modify the fundamental requirement that an application originate from a Nova Scotia specialist. Consequently, patients who cannot access such a specialist remain unable to meet program criteria.

35. The Department will need to establish a mechanism to identify cases where no appropriate Nova Scotia specialist exists and provide an alternative pathway for these patients to access medically necessary assessment and treatment.

36. Since the judicial review, we were informed of another patient with a condition for which no Nova Scotia specialist exists. At the time of our audit, this patient was experiencing similar challenges accessing medical care.

Department has adopted tailored Gender Affirming Care Policy to address capacity and access barriers

37. The Department's Gender Affirming Care Policy outlines the coverage, eligibility criteria, assessment, and approval process for accessing insured gender affirming surgeries within and outside Nova Scotia. Referrals must meet established clinical requirements, including assessment by qualified healthcare professionals.

38. Historically, limited access to certain gender affirming surgical services within Nova Scotia resulted in those services being considered unavailable locally. To address these access barriers, the Department permitted eligible patients to choose whether to receive insured services within Nova Scotia or at an approved facility outside the province, when appropriate.

39. Nova Scotia has been referring eligible patients to a Montreal clinic since April 2014. In April 2025, this long-standing referral relationship was formalized through a Memorandum of Understanding with the clinic. While insured gender affirming procedures are available in both Nova Scotia and Montreal, three insured gender affirming procedures remain available only through the Montreal clinic.

40. Prior to the judicial review decision date, gender affirming services made up 59% (699) of applications for out-of-province care between January 2022 and November 2024, and 42% (83) of applications between November 2024 and April 2025. Our testing of applications to the out-of-province medical program included 11 examples of individuals seeking gender affirming services. Eight were for procedures available in Nova Scotia but were referred to the Montreal clinic. In five of those eight applications, the physician applicant noted the patient's request to have the surgery at the Montreal clinic.

41. Department has demonstrated, through its Gender Affirming Care Policy, that it can design and implement a tailored approach to support patients requiring out-of-province care when local capacity is limited or access barriers exist. This policy provides flexibility in referral pathways, recognizes gaps in provincial services, and enables patients to access care outside Nova Scotia when appropriate. A similar policy-based approach could be applied to patients who are unable to access a recognized Nova Scotia specialist. Establishing a defined mechanism to identify and support these cases would improve consistency, transparency, and fairness in decision-making.

Recommendation 1

We recommend the Department of Health and Wellness identify cases where no appropriate Nova Scotia specialist exists and establish and implement an alternative pathway for these patients to have their eligibility assessed.

Department Response to Recommendation 1

Department agrees

Target Date for Implementation:

September 2027

The Department agrees with the recommendation's objective of ensuring a clear and consistent approach for patients whose circumstances may involve limited or unavailable specialist expertise in Nova Scotia. The Department recognizes that rare, complex, or emerging conditions can present challenges in accessing appropriate specialist assessment and will strengthen existing processes to identify these cases and support patients in accessing the specialist expertise required to evaluate their condition and, where clinically appropriate, support an application for out-of-province or out-of-country services.

The Department will address these circumstances within existing program processes and does not support establishing a separate eligibility pathway. A referral from a qualified specialist remains an essential safeguard to confirm medical necessity, ensure appropriate clinical oversight, consider available treatment options, support continuity of care, and promote responsible stewardship of public resources. This approach is consistent with existing legislative and policy requirements and reflects standard referral-based assessment practices across Canadian jurisdictions.

Oversight Weaknesses Result in Duplication, Inconsistent Data, and Limited Performance Monitoring

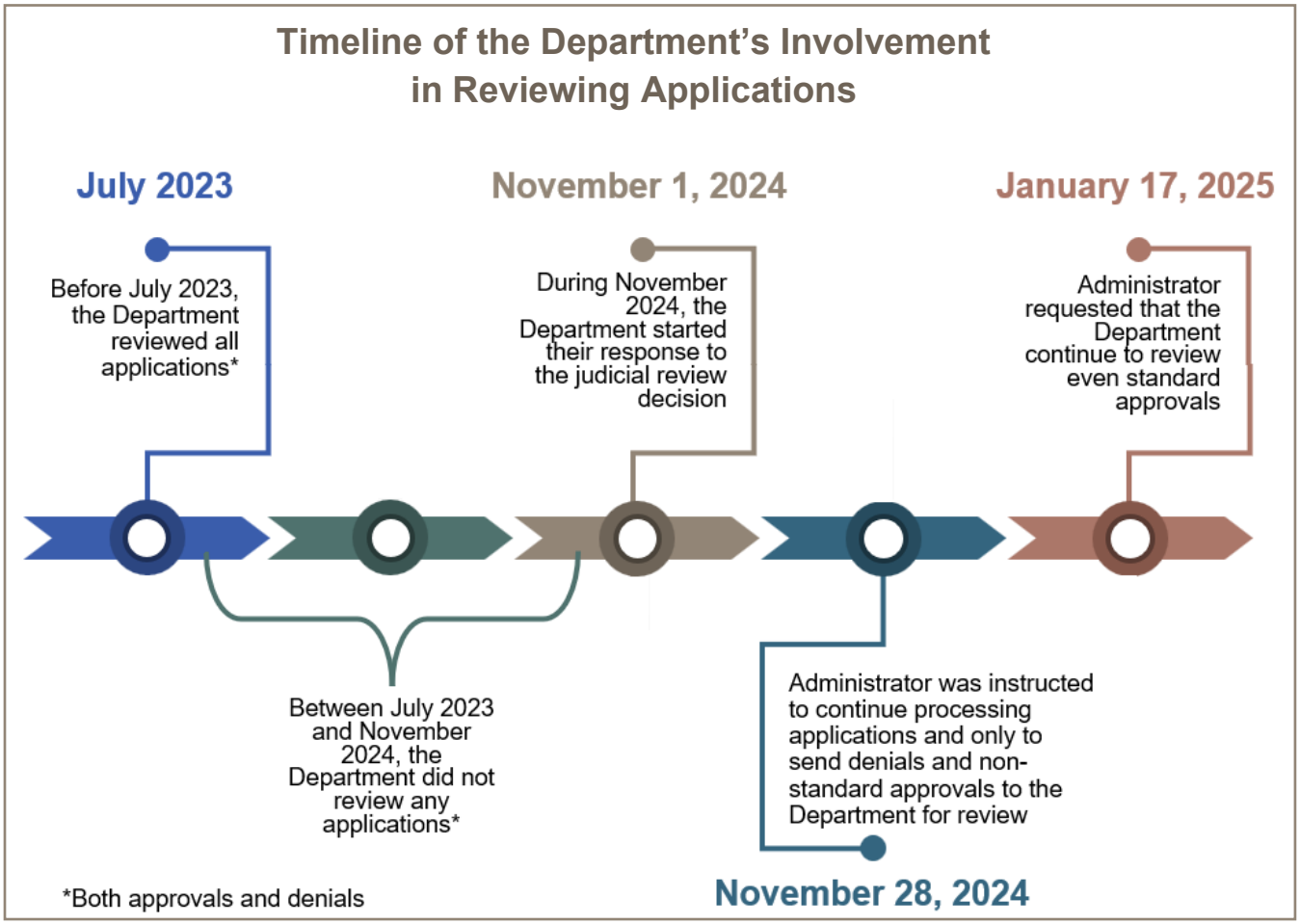
Duplication of review efforts by the Department and the Program Administrator has slowed response times and is not cost-effective

42. Over the last several years, the Department's involvement in reviewing applications has varied significantly.

43. Prior to July 2023, the Department reviewed all application decisions made by the Program Administrator. Between July 2023 and November 1, 2024, the Department stopped reviewing decisions and the Program Administrator independently reviewed and responded to all applications.

44. Immediately after the judicial review decision was released on November 1, 2024, the Department resumed responsibility for reviewing all applications. Four weeks later, on November 28, 2024, the Department instructed the Program Administrator to continue processing and to just share denials and non-standard approvals with the Department for review.

45. After the first round of approvals were sent to physician applicants in January 2025, the Program Administrator requested that the Department begin reviewing all applications, even standard approval letters. The Program Administrator believed this would be the best course of action while the policies were under review.



Source: Office of the Auditor General of Nova Scotia

46. Under the current process, established after November 1, 2024, the Program Administrator reviews all applications and prepares a proposed decision and response letter. These documents are forwarded to the Department for a second review. The Department reviews the proposed decision and may edit the response letter.

47. During the audit, we noted the dual-review model led to an increase in response times, and a longer delay for patients in receiving a response. In the sample of applications we

examined, the average response time for rejected applications increased from an average of eight days in the sample tested before the judicial review to an average of 29 days in the sample tested afterward. In the sample of appeals we examined, the response times went from an average of 17 days in those tested before the judicial review to an average of 35 days in the sample tested afterward.

48. The current dual-review model is inefficient. Although the third-party Program Administrator has been contracted to administer the Program on behalf of the Department, the Department is currently reviewing all work of the Program Administrator and duplicating its work. The Department's oversight of the Program would be more effective if it focused on non-standard or complex applications or areas requiring judgment, such as appeals, rather than reperforming the Program Administrator's work. Duplicating all efforts calls the efficiency of this arrangement into question.

Recommendation 2

We recommend the Department of Health and Wellness establish and apply criteria defining a standard application and determine when additional Departmental review of applications and appeals should occur.

Department Response to Recommendation 2

Department agrees

Target Date for Implementation:

September 2028

The Department agrees with the recommendation to strengthen criteria defining standard applications and clarify when additional Departmental review should occur. Existing policies outline application requirements; however, they do not provide sufficient detail to consistently distinguish routine cases from those requiring escalation. The Department also notes that current policies do not explicitly set expectations for a human-centered approach, although Departmental oversight has supported more consistent and personalized communication while broader policy updates are underway.

The Department will establish criteria to distinguish standard applications from cases requiring additional review and define clear escalation thresholds for complex, non-routine, or precedent-setting matters. The updated approach will support effective oversight, reduce unnecessary duplication, improve consistency in decision-making, and promote timely processing while maintaining appropriate safeguards and accountability.

Inconsistant data collection complicates analysis

49. From our analysis of program applications and appeals, we noted standard wording is not used to document the diagnosis or procedures outlined in both applications and appeals.

50. The absence of standardized data collection limits the Department's ability to analyze trends in Program usage. Consistent terminology and regular analysis would allow the Department to better understand the types of conditions for which patients are seeking treatment outside Nova Scotia.

51. Improved data collection and analysis could also help the Department identify recurring conditions that require out-of-province treatment due to the absence of an appropriate specialist in Nova Scotia. Over time, this information could support broader health system planning by highlighting conditions where demand for out-of-province care may warrant consideration of recruiting or developing specialist expertise within the province.

Recommendation 3

We recommend the Department of Health and Wellness require the Program Administrator to:

- Collect program data using standard medical diagnoses for applications and appeals; and
- Regularly analyze this information to identify trends including recurring conditions and cases where no Nova Scotia specialist exists.

Department Response to Recommendation 3

Department agrees

Target Date for Implementation:

September 2027

The Department agrees that the Program Administrator should implement standardized diagnostic coding to support consistent data collection, reporting, and analysis. While clinical terminology currently varies depending on data entry practices, applications can generally be reviewed and categorized appropriately; however, greater standardization will improve data quality, reliability, and usability.

The Department also agrees that regular analysis of standardized data would strengthen oversight of Program utilization and support identification of recurring conditions, emerging trends, and circumstances where specialist expertise may not be available within Nova Scotia.

The Department will work with the Program Administrator to implement standard diagnostic coding and establish regular monitoring and reporting of program activity, including applications, approvals, denials, appeals, and inquiries. Over time, this information may support broader health system planning and assist in identifying areas requiring additional specialist capacity.

The Department does not monitor program performance through key performance indicators

52. The Department has not established, and therefore does not monitor, key performance indicators to assess either the program's success or the performance of its Program Administrator.

53. For example, the Program's policies require a response within 30 days of receiving the completed application or appeal. However, the Department does not track whether this service standard is met. Without monitoring response times, the Department cannot assess compliance with its own policy requirements.

54. The Department also does not collect or analyze data related to application volumes, approval and denial rates, appeal outcomes, or common deficiencies in submitted applications. Monitoring this information could help the Department to:

- Identify trends and emerging pressures within the Program;
- Determine whether certain application categories could be streamlined;
- Identify recurring documentation gaps that may signal a need for clearer public guidance; and
- Assess whether decision-making is consistent with policy intent.

55. In the absence of defined performance measures and regular monitoring, the Department lacks assurance the program is delivered efficiently, consistently, and in accordance with its objectives. This limits the Department's ability to exercise effective oversight of the Administration Services Agreement.

Response times to applicants exceeded policy requirements

56. Department policies require responses to all completed applications and appeals within 30 days of receipt. Timely responses are critical to ensuring patients can access necessary medical care or make alternative arrangements without unnecessary delay.

77 days

The longest an applicant waited for a response to their application

57. Our testing identified instances where this requirement was not met:
    - Two of 10 denied applications were answered after 37 and 41 days.
    - Six of 25 approved applications exceeded the 30-day requirement, with response times between 31 and 77 days.
    - One of the eight appeals tested was not answered until 74 days after receipt.

58. These delays are significant given the nature of the program. Patients rely on timely decisions to proceed with out-of-province or out-of-country medical treatment. A delay in response may slow down access to care, increase financial uncertainty, and undermine confidence in the program's administration. The absence of effective monitoring also increases the risk delays will go unnoticed and not be corrected.

Recommendation 4

We recommend the Department of Health and Wellness strengthen oversight of the Program by:

- Establishing performance measures, including response time standards;
- Monitoring and reporting on performance against these measures; and
- Establishing and implementing a process for corrective action where service standards are not achieved.

Department Response to Recommendation 4

Department agrees

Target Date for Implementation:

September 2027

The Department agrees with the recommendation to strengthen oversight through performance measures, response time standards, regular monitoring, and corrective action processes where required.

The Department recognizes that response times can vary depending on application complexity, completeness of information, and the need for additional clinical or administrative review. While some applications may require additional assessment, applicants should receive timely communication regarding the status of their request.

The Department will establish performance measures and reporting processes, including monitoring against response time standards, and will review performance on a regular basis. Interim communication expectations will also be formalized for files requiring additional review beyond established service standards.

The Department will work with the Program Administrator to implement these measures, identify service gaps, and establish corrective actions where performance expectations are not met.

The Department Did Not Have a Human-centred Approach to Review Applications

Outdated policies lack human-centred guidance

59. The Department had two policies which governed the program before the judicial review:
    - one related to out-of-province medical claims; and
    - one related to out-of-country medical claims.

60. Following the judicial review in 2024, the Department reviewed both programs and their related policies. The out-of-province medical claims policy was partially revised in 2025 for travel and accommodation claims. However, portions relating to application requirements remained unchanged. The out-of-country policy has not been updated since 2010. Therefore, both policies remain silent on how a human-centred approach can be achieved when reviewing and responding to applications.

61. The lack of guidance for a human-centred approach was not surprising, as the original purpose of the program was for communication to flow between the referring physician and the medical consultant and not directly to the patient. However, given the findings of the judicial review, it is apparent that in some circumstances, communication does go directly to patients. Without clear policy guidance, responses to patients in need of out-of-province care will not consistently be human-centred.

Testing shows majority of denials and appeals issued before November 2024 did not use human-centred approach

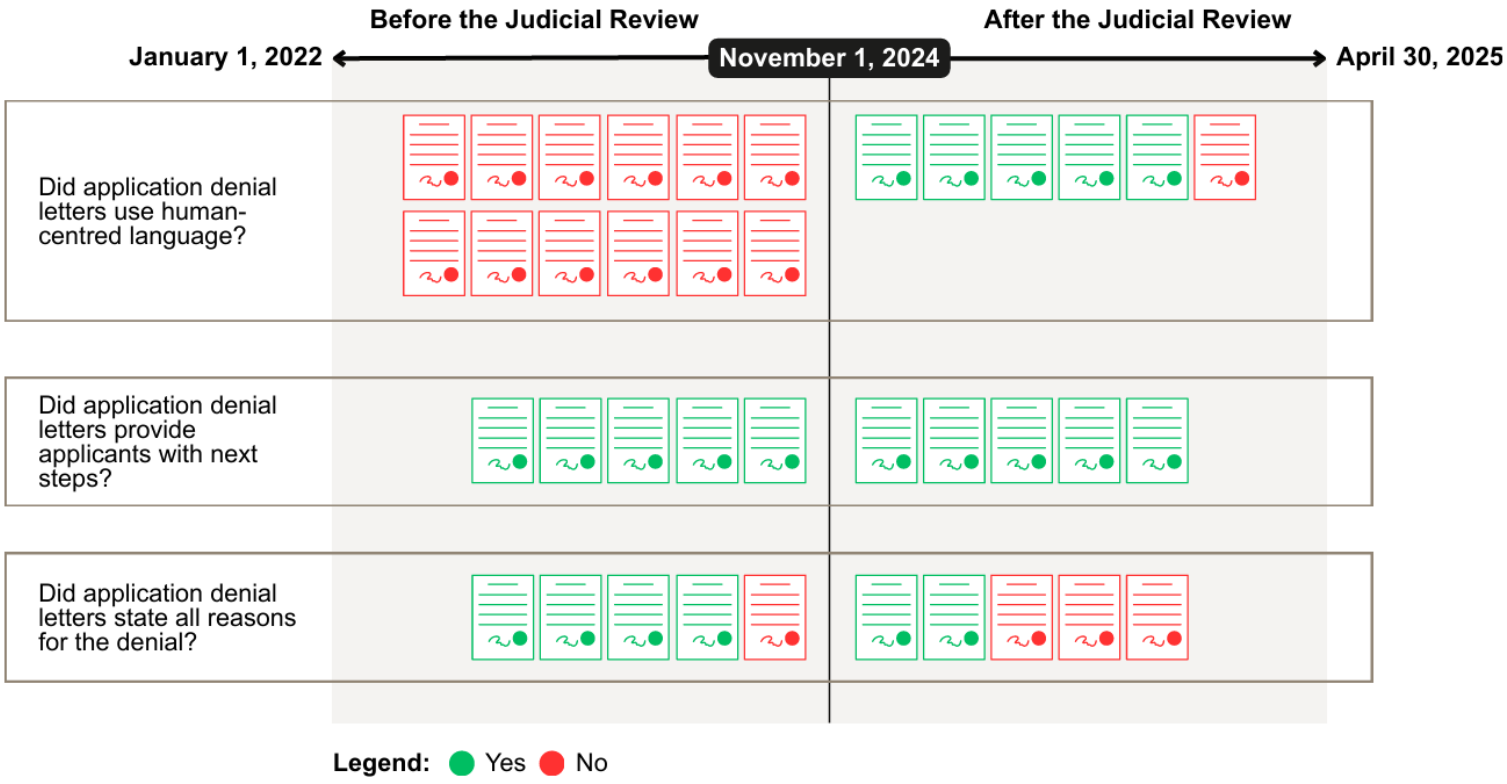
62. Before November 2024, the Program was not intended to be patient-focused; it was instead intended to be a means of communication for the physician applicant who would in turn communicate the results to the patient.

63. Due to the program's design, these letters were written in a direct, matter-of-fact tone that, if provided to patients seeking Program approval, could be perceived as harsh, as they were not drafted with a patient-centred approach in mind.

64. For the response to an application to be human-centred, it should demonstrate respect for the patient and an understanding of their situation. Denial letters should cite all reasons for the denial, including the unfulfilled Program requirements to allow the physician applicant or the patient the opportunity to provide additional information; and outline next steps such as appealing the decision.

65. Our testing found all 12 applications denied before the judicial review did not use human-centred language.

Summary of Testing for a Human-Centred Approach in Denied Applications



Source: Office of the Auditor General of Nova Scotia

66. Using human-centred language in denial letters can help foster patient trust in the healthcare system. Clear, empathetic, plain-language communication can help patients understand why their application for services was denied, and outline the steps required to appeal a decision. This approach may better allow patients to navigate a complex and stressful healthcare process.

Following the judicial review, the Department improved the tone and human-centred language in response to applications, but more improvements needed

67. After the judicial review, the Department opted to review all decision letters before replies were sent by the Program Administrator. We tested a sample of six denial letters after the judicial review and found that five letters used human-centred language. Additionally, all four appeal responses tested after November 2024 made use of human-centred language.

Applicants are not being told all the reasons their application is denied

68. In our testing of denial letters prior to the judicial review decisions, we found one of the five denials tested did not provide all the reasons for the denial. In that case, there were three reasons for the denial, but only one was communicated to the applicant in the letter.

69. After the judicial review decision, we continued to see a similar pattern where applicants were not provided with all the reasons for their denied application. Of the five denial letters we tested after November 2024, three letters included only one reason for the denial, even though there were up to four reasons for the negative outcome. If all reasons for denial are not communicated to the applicant, they might resubmit incomplete applications only to be denied again, leading to unnecessary and frustrating delays.

Recommendation 5

We recommend the Department of Health and Wellness update the out-of-province and out-of-country medical claims policies to include a human-centred approach throughout the review, decision-making, and communication processes.

Department Response to Recommendation 5

Department agrees

Target Date for Implementation:

September 2028

The Department agrees that the out-of-province and out-of-country medical claims policies should be updated to further reflect a human-centred (patient-centred) approach to assessment, adjudication, and communication.

Historically, communications were primarily intended for physician-to-physician communication between the referring specialist and the Medical Consultant. As a result, correspondence often reflected a direct and matter-of-fact style rather than a human-centred approach. The Department acknowledges that these communications may also be shared with patients and would benefit from clearer, more patient-centred language and explanations.

Since November 2024, Departmental oversight of decision letters has improved consistency in tone and language. The Department will update policies to incorporate human-centred communication principles, clarify expectations, and ensure all relevant reasons for decisions are communicated consistently and transparently.

Existing policy direction for the Program Administrator requires further clarification

70. The Administration Services Agreement signed between the Department and the Program Administrator lists the governing legislation and policies for standard program delivery. However, it does not specifically reference the out-of-province and out-of-country claims program. While the agreement includes overarching requirements for compliance with Department legislation and policy, including that the Program Administrator's procedural documents related to the administration of the contract will be compliant with all related Department policies, applicable legislation, regulations and by-laws, it does not clearly identify the specific out-of-province and out-of-country claims policies applicable to program administration. Further, we noted additional gaps in existing policies where additional direction and clarification for the Program Administrator could improve consistency in program administration.

Internally developed review tool highlights gap in Department guidance

71. The Program Administrator created its own internal checklist to assist the Medical Consultant in assessing applications against the requirements of the Program. The checklist is not required to be completed but is a good way to make sure the application process is followed.

72. The checklist requirements matched the requirements of the Department's policies, making it a useful tool against which to assess program application requirements. From our testing of the use of the checklist, we noted the following:
    - Five out of the 10 denied applications had no checklist completed. All of these were prior to the judicial review in November 2024
    - Six out of eight appeals did not have a complete checklist
    - One out of 25 approved applications did not have a completed checklist.

73. The checklist developed by the Program Administrator represents a practical step toward promoting consistency in application review. Without defined and mutually agreed-upon processes, there is a risk review practices may not be consistently applied or aligned with Departmental intent, resulting in inefficiencies or inconsistent outcomes.

74. The Department needs to provide clear guidance to the Program Administrator on how to assess and respond to applications and appeals. This guidance could include checklists, providing templates for responses and requiring all reasons for denying an application or appeal to be communicated to the applicant.

Criteria applied in practice are not fully reflected in policy or public guidance

75. Some criteria are applied in practice but are not clearly defined in policy or in publicly communicated information. For example, prior to November 2024, while the out-of-province

policy does not explicitly require applications to state whether the referral is to a publicly funded facility, some applications were historically denied on the basis that services would be received at private facilities.

76. The Program Administrator's internal checklist includes this as a consideration. In listings provided by the Department, 11 of 109 denials between January 2022 and the November 2024 judicial review decision were related to referrals to private facilities.

77. Another key requirement of the Program is that applications must demonstrate the availability, or lack there of, for the requested service within Nova Scotia -- or within Canada for out-of-country claims. This responsibility rests with the referring physician. In our sample of 25 approved applications, two applications did not include any information regarding the availability of the service in the province.

78. When application criteria are not clearly defined or consistently enforced, responsibility shifts from the referring physician to the Program Administrator. This increases administrative burden and could introduce subjectivity into the review process.

Operational procedures of the Program Administrator are incomplete and not aligned with Department policy

79. The Program Administrator developed a procedure manual to support delivery of services under the Administration Services Agreement. The Department has had the opportunity to provide input on the manual.

80. The procedure manual primarily focuses on claims adjudication and payment processing — that is, after travel and services have occurred. It provides limited guidance on application assessment at the intake and review stages.

81. The manual does not outline the documentation required for a complete application, nor does it provide standardized templates or guidance for approval and denial letters. Due to the lack of Department direction, the Program Administrator developed its own internal checklist to assess applications against policy requirements. The checklist was not required by the Program Administrator's process, and as a result the checklist was not always completed in the files we tested.

82. We also identified inconsistencies between the Program Administrator's procedure manual and Department policies. For example, the Program Administrator's manual references escorts in the context of gender-affirming services only, whereas the Department's policies do not provide an automatic entitlement for escorts in those cases.

83. These differences, combined with limited procedural direction, suggest a disconnect between the Department's policies and the Program Administrator's operational guidance. Without clear, Department-approved procedures, there is a risk of inconsistent decision-making and program delivery that does not fully meet program objectives.

Recommendation 6

We recommend the Department of Health and Wellness improve and clarify guidance to the Program Administrator for the out-of-province and out-of-country program, including guidance for:

- Application documentation;
- Tools to assess applications and appeals; and
- Requirements for communications with applicants, including approvals, denials, and appeals.

Department Response to Recommendation 6

Department agrees

Target Date for Implementation:

September 2027

The Department agrees that additional procedural guidance is required to support consistent application assessment, appeals processing, decision-making, and communication practices.

The Department will work with the Program Administrator to establish and document detailed procedures aligned with current policies and program eligibility criteria. This work will include clarification of documentation requirements, assessment processes, standardized tools, and communication expectations for approvals, denials, and appeals.

The Department will also support the review and refinement of assessment tools used by the Program Administrator, including checklists and decision-support resources used by the Medical Consultant, to promote consistency and transparency.

While Department policies provide overall program direction, the Department agrees that operational procedures should more clearly align with policy requirements and reinforce expectations regarding documentation, standardized assessment practices, and human-centered communication.

Appeals Process Lacks Clear Guidance on Roles, Documentation, and Expectations

The appeals process lacks decision-maker independence and clear policy direction

84. When an application to the Program is denied, patients may appeal the decision. During this appeal, the original application and any additional information are reassessed to determine whether policy requirements have been met. The outcome of this review may either uphold the original denial or overturn it and approve the request.

85. The Department's policies do not define how appeals are to be conducted by the Program Administrator. Specifically, they do not identify who is responsible for reviewing appeals, what qualifications are required, or whether the review must be independent of the original decision-maker.

86. While initial applications are required to be reviewed by a medical consultant, there is no equivalent requirement for appeals. While there is reference to the medical consultant's role in the administrative agreement, this is not reflected in department policy. As a result, appeals may be reviewed by individuals without the necessary medical expertise to appropriately assess new clinical information. In our testing, the responses to five of eight appeal decisions were from individuals who were not medical consultants. Three of these appeals occurred after the November 2024 judicial review decision.

87. The Program Administrator's procedure manual does not outline how appeals should be assessed beyond noting they are to be submitted to the Program Administrator. The policies do not address independence of the appeal reviewer, required qualifications, documentation standards, or communication expectations. The policies also do not require completion of the Program Administrator's checklist during the appeal process, nor do they provide guidance on how to respond using a human-centred approach. This increases the risk appeals will be handled inconsistently and without adequate documentation to support decisions.

88. In addition, three of the eight appeals tested were reviewed by the same medical consultant who made the original denial decision. Although two of these decisions were ultimately overturned, allowing the original decision-maker to evaluate their own work creates a risk of perceived or actual bias in the decision-making process. Independent review is a good practice in administrative decision-making, as it strengthens objectivity, fairness, and public confidence in the process.

Appeal provisions are inconsistent and public information does not align with policy

89. The out-of-province travel and accommodation policy states "the resident" may appeal if a decision is denied. The policy defines a resident as a person who is legally entitled to remain in Canada and who makes Nova Scotia their home.

90. In contrast, the out-of-country medical claims policy states an appeal may be requested by "the eligible resident or the referring specialist." The policy defines "eligible resident" as a person insured under the *Health Services and Insurance Act*.

91. As a result, the two policies are not consistent with respect to who may initiate an appeal. The out-of-province policy restricts appeal requests to the resident, while the out-of-country policy permits either the resident or the referring specialist to request an appeal.

92. Further, the Department's external website states anyone may request an appeal on their own or on behalf of a close family member. This description does not align with either policy.

93. Inconsistent language between policies, combined with publicly available information that does not reflect policy requirements creates confusion and may result in appeals being submitted by individuals who do not have standing under the written policy. Clear, consistent, and aligned communication is necessary to provide transparency and fairness in the administration of the Program.

Recommendation 7

We recommend the Department of Health and Wellness establish a clearly communicated appeals process which:

- Requires appeals to be reviewed by a qualified individual with appropriate medical expertise;
- Prohibits the original decision-maker from reviewing their own decision;
- Defines documentation requirements, including completion of standardized review tools;
- Provides guidance on communicating appeal decisions using a human-centred approach; and
- Is publicly available to physician applicants and patients.

Department Response to Recommendation 7

Department agrees

Target Date for Implementation:

September 2028

The Department agrees that the appeals process requires clearer policy direction, documentation requirements, public transparency, and defined review responsibilities.

In practice, appeals are accepted from the referring provider, patient, or an individual authorized by the patient. The Department agrees that policies should be updated to accurately reflect established practice and ensure there are no unnecessary administrative barriers to submitting appeals.

Under the Administration Services Agreement, appeal reviews currently involve the Medical Consultant, who provides the clinical expertise required to support review of clinical information. The Department will update policies to clearly document review responsibilities, establish independence requirements so that original decision-makers do not review their own decisions, and ensure procedural and public-facing materials consistently reflect these requirements.

The Department will also support development and implementation of standardized review tools and ensure public-facing information reflects the updated appeals process.

Program Information is Not Readily Available to the Public and Physicians

Program requirements are not clearly communicated to the public

94. The Department's policies outline specific required documentation for Program applications. While internal policies are not required to be publicly posted, the key program requirements including required documentation and service standards are not clearly communicated on the Department's website or through publicly accessible materials.

95. Although some requirements are referenced in the Regulations, these are not written in plain language and are not easily navigable for members of the public seeking medical care outside the province.

96. Department policies require responses to applications and appeals within 30 days of receipt of the completed application or appeal. However, at the time of our audit this service standard was not publicly disclosed.

97. Without clear, accessible, public information outlining required documentation, timelines, and appeal rights, applicants may submit incomplete applications or be unaware of expected response times. This may contribute to processing delays, increased administrative burden, and frustration for patients navigating complex medical circumstances seeking time-sensitive medical care outside of Nova Scotia.

Program requirements are difficult to find and not proactively communicated

98. In collaboration with the Department, the Program Administrator developed a physician bulletin containing all relevant program requirements. The bulletin includes contact details for completed application submission and how to obtain further guidance regarding the program. We reviewed the bulletin and found it to have been reviewed by the Department and is consistent with the Program policy requirements.

99. The bulletin is publicly available but not readily accessible to physicians and other interested parties as it is listed on the Program Administrator website by its date (Physician's Bulletin July 21, 2023), with no indication of its contents. The information would also be hard for the public to locate, as they may not know about the existence of the bulletins or the bulletins' contents.

100. Physicians and in particular newer physicians may not read all bulletins. Without proper information, applications could be subject to unnecessary delays or denials of care as physicians or their patients navigate the requirements of the program.

Information on the websites could be misleading to program applicants

101. The Program was designed for physician-to-physician communication. Although high-level information about the Program was available on the Department's website at the time of our audit, detailed submission requirements were not.

102. Two main links from the Department's home page provided more information about the program, including 'MSI Out-of-province Claims' and the 'MSI Moving and travel' links. From our review of these webpages, we noted contradictory statements which could be misleading for applicants. For example, the page detailed that out-of-province and out-of-country medical claims required a patient's application to come from a medical professional who is on the Specialist Register of the College of Physicians and Surgeons of Nova Scotia. They are referred to as 'appropriate specialists' in the policy. The policy further states the appropriate specialist should be actively involved in the care of the patient, a concept not defined in the policy.

103. The 'Travel and Accommodation Assistance' webpage stated the application should be from an "appropriate specialist." However, the webpage did not provide an accompanying definition, and it was not clear if the requirement to be a Nova Scotian physician applied.

104. The Program Administrator's website goes one step further to state the physician should be "a specialist registered in Nova Scotia," but is silent on the requirement for the specialist to be actively involved in the patient's care. The Program Administrator's website only states this requirement for out-of-county medical claims. According to internal Department policies and from our testing, we noted it is a program requirement for a physician to be actively involved in the patients' care for out-of-province medical claims as well.

Potentially Misleading Information on Websites

Requirement by policies*	MSI Out-of-Province Claims Website	Travel and Accommodation Assistance Website
"Application...by an appropriate** specialist actively involved in the eligible resident's care in Nova Scotia"	Only noted for out-of-country program: "The referral must be from a specialist registered in Nova Scotia."	Implied for both programs: "...referral is completed by the appropriate* physician specialist..."

*The out-of-province and out-of-country medical claims policies
***Appropriate* is defined in the policy; however, no definition is publicly available

Source: Office of the Auditor General of Nova Scotia

105. Of the 18 denied applications we tested, seven denials were due to the application originating from an inappropriate specialist, suggesting the application criteria may not be clear to all applicants.

106. All program requirements should be available and clear to applicants. This could be done by providing details on the website and/or making a standard application form which lists all required information to ensure an application is complete before it is submitted.

Recommendation 8

We recommend the Department of Health and Wellness publish easily accessible, clear, plain-language guidance for physician applicants and patients aligned with program practices and policies, including:

- application requirements;
- required documentation; and
- response time standards.

Department Response to Recommendation 8

Department agrees

Target Date for Implementation:

Completed (March 2026)

The Department agrees with the recommendation to provide clear, plain-language public guidance on application requirements, documentation requirements, and service standards.

This issue had already been identified by the Department and addressed through the launch of a new public website that consolidates relevant program information previously available primarily through the MSI Physician Bulletin. Information is now accessible in plain language for both Nova Scotians and health care providers through a more user-friendly and accessible platform.

The website includes information on eligibility requirements, application processes, required documentation, appeals, and expected response time standards, including how applicants will be informed of decisions.

This improvement enhances transparency, supports submission of more complete applications, and promotes greater consistency in program administration.

Appendix I

Reasonable Assurance Engagement Description and Conclusions

We completed an independent assurance report of the out-of-province and out-of-country medical claims program at the Department of Health and Wellness. The purpose of this performance audit was to determine if the Department of Health and Wellness has an appropriate and human-centric approach in managing the out-of-province and out-of-country medical claims program.

It is our role to independently express a conclusion whether the out-of-province and out-of-country medical claims program complies in all significant respects with the applicable criteria. Management at the Department of Health and Wellness have acknowledged their responsibility for the out-of-province and out-of-country medical claims program.

This audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001—Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook - Assurance; and sections 18 and 21 of the *Auditor General Act*.

We apply the Canadian Standard on Quality Management 1 (CSQM 1), and we have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Nova Scotia.

The objectives and criteria used in the audit are below:

Objective(s): To determine if the Department of Health and Wellness has an appropriate and human-centric approach in managing the out-of-province and out-of-country medical claims program.

Criteria:

1. The Department of Health and Wellness has a human-centred process to review out-of-province and out-of-country medical claim applications.
2. The Department of Health and Wellness has a clear and transparent appeals process for applicants who have been denied under the out-of-province and out-of-country medical claim process.
3. The Department of Health and Wellness has implemented appropriate changes to the process resulting from 2024 internal review into the out-of-province and out-of-country medical claim process.
4. The Department of Health and Wellness is providing sufficient oversight of the Program Administrator to administer the program.
5. The Department of Health and Wellness has made information publicly available to assist Nova Scotians and physicians navigating the out-of-province and out-of-country medical services process.

Generally accepted criteria consistent with the objectives of the audit did not exist. Audit criteria were developed specifically for this engagement. Criteria were accepted as appropriate by senior management at the Department of Health and Wellness.

Our audit approach included conducting interviews with management and staff, reviewing policies, examining processes, analysis and discussion to inspection, observation, and confirmation. Our audit period was from January 1, 2022 to April 30, 2025. We examined information outside of that period as necessary.

We believe the evidence we have obtained is sufficient and appropriate to provide the basis for our conclusion. Our report is dated September 4, 2026 in Halifax, Nova Scotia.

Based on the reasonable assurance procedures performed and evidence obtained we have formed the following conclusions:

The Department of Health and Wellness did not have an appropriate and human-centric approach to manage the out-of-province and out-of-country medical claims program.

- The Department did not have a human-centric approach to review out-of-province and out-of-country medical claim applications. Although we can see improvements in the tone and human-centred language used to respond to applications following the judicial review, denial letters do not state all reasons for the denial, and response times are longer than the 30 days set out in the policy.

- The Department does not have a clear and transparent appeals process. Program documentation regarding appeal eligibility is not consistent, and our testing noted some appeals were reviewed by the same individual who issued the initial denial.

- The changes implemented by the Department after the judicial review resulted in more review of Program Administrator decisions. Patients without in-province specialists still face an unclear and difficult pathway to access medical care.

- The Department is not providing sufficient oversight of the Program Administrator. The Department is reperforming the work of the Program Administrator, creating unnecessary duplication. Limited guidance is provided by the Department to the Program Administrator, and there are no key performance indicators to monitor the performance of the Program Administrator.

- The Department has made limited information available to Nova Scotians and physicians. Some Program information is not readily accessible, clearly written, or consistent with internal policies and procedures.

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