Ministry of Health and Long-Term Care

# Funding Alternatives for Specialist Physicians

## Background

Physicians may provide specialized services in over 60 areas, including cardiology, gynecology, orthopaedics, pediatrics, and emergency services. These specialists work in various settings, including hospitals and their own offices.

In the 1990s, the Ministry of Health and Long-Term Care (Ministry) introduced funding alternatives (known as alternate funding arrangements) for some specialist physicians to encourage them to provide certain services, such as academic services (including training new physicians and conducting research) and working in remote areas of the province. Before this, the Ministry paid specialist physicians on a fee-for-service basis for the different clinical services involved in diagnosing and treating patients, but did not compensate specialists for these other services. In 1999, the Ministry also introduced specialist alternate funding arrangements for physicians, generally family physicians, for providing emergency services in hospitals. Most of the specialists paid through alternate funding arrangements may also bill the Ministry on a fee-for-service basis for patient care provided outside the arrangement.

Alternate funding arrangements are contractual agreements between the Ministry, a group of physicians, and in most cases the Ontario Medical Association (the organization that bargains on behalf of physicians in Ontario) and may include other organizations such as hospitals and universities. Alternate funding arrangements for specialists are also subject to provisions in the physician services agreements between the Ministry and the Ontario Medical Association, which have been negotiated every four years since 2000.

In the 2009/10 fiscal year, the Ministry paid almost $1.1 billion, as shown in Figure 1, under specialist alternate funding arrangements to more than 9,000 physicians. This represents about 17% of the $6.3 billion the Ministry paid to all specialists that year. As of March 31, 2010, 50% of the almost 13,000 specialists in the province and more than 90% of the 2,700 emergency department physicians were paid, at least in part, through a specialist alternate funding arrangement.

## Audit Objectives and Scope

This year, our Office performed two audits on funding alternatives (known as alternate funding arrangements) for physicians. The audit discussed in this section focused on the arrangements for specialist physicians, and the audit in Section 3.06

**Figure 1: Number of Physicians Participating in Specialist Alternate Funding Arrangements and Associated Payments, by Agreement Type**

Source of data: Ministry of Health and Long-Term Care

| Agreement Type | # of Physicians as of March 31, 2010 | Payments for 2009/10 Fiscal Year ($ million) |
|---|---|---|
| academic comprehensive [1] | 1,234 | 268 |
| Academic Health Science Centres [2,3] | 3,692 | 242 |
| emergency departments | 2,653 | 315 |
| northern specialists [3] | 280 | 39 |
| other | 1,181 | 208 |
| **Total** | **9,040** | **1,072** |

1. Unique alternate funding arrangements for academic services, including training new physicians and conducting research.
2. Standard alternate funding arrangement for academic services, including training new physicians and conducting research.
3. Excludes fee-for-service payments to participating physicians for clinical services.

focused on those for family physicians. Our audit objective was to assess whether the Ministry of Health and Long-Term Care (Ministry) has implemented systems and processes to monitor and assess whether alternate funding arrangements provide Ontarians with timely access to specialist physicians in a cost-effective manner. Ministry senior management reviewed and agreed to our objectives and associated audit criteria.

Given the number of different alternate funding arrangements for specialists, our audit focused primarily on arrangements with academic physicians (whose responsibilities generally include training new physicians and conducting research) and emergency department physicians, and to a lesser extent on payments to specialists working in Northern Ontario. Contracts with these groups currently encompass over 85% of physicians who participate in a specialist alternate funding arrangement.

Our audit work was conducted primarily at the Ministry's Negotiations Branch in Toronto, which is responsible for managing the specialist physician contracts, as well as at other ministry branches in Toronto. In conducting our audit, we reviewed relevant files, systems, and administrative policies and procedures; interviewed appropriate ministry staff; and reviewed relevant research from Ontario and other jurisdictions. We also reviewed data received from the Ministry's Ontario Health Insurance Plan database. We did not rely on the Ministry's internal audit service team to reduce the extent of our audit work, because it had not recently conducted any audit work on alternate payment arrangements for specialists or emergency department physicians.

## Summary

Payments made under alternate funding arrangements for specialists and emergency department physicians increased by more than 30% from the 2006/07 fiscal year to almost $1.1 billion in the 2009/10 fiscal year, or more than 10% per year, similar to the increase in payments to all specialists during this time. By 2009/10, payments made under alternate funding arrangements accounted for about 17% of all payments to specialists and emergency department physicians. However, the Ministry has conducted little formal analysis of whether the expected benefits of these alternate funding arrangements, such as improving patient access, have materialized or have been cost-effective. For instance, payments to emergency department physicians increased by almost 40% between the 2006/07 and 2009/10 fiscal years, while the number of physicians working in emergency departments increased by only 10% and the number of patient visits increased by only 7%.

We also noted that although the Ministry indicated that it performed a cost/benefit analysis before it entered into any alternate funding arrangements, it was unable to provide us with any such analysis relating to the arrangements that most of the physicians participated in. Additionally, the relative complexity of the different

arrangements and the relative scarcity of performance measures in the contracts have made it difficult for the Ministry to effectively monitor both the accuracy of payments being made and the extent to which physicians have actually provided the services expected in their contracts.

Some of our more significant observations are as follows:

- The Ministry has made progress in implementing standard contracts for most specialists, and these contracts are now in place for more than 70% of physicians participating in specialist alternate funding arrangements.
- The Ministry does not track the total amounts paid to physicians participating in Academic Health Science Centre (AHSC) and northern specialist alternate funding arrangements, and therefore cannot readily perform any subsequent assessment of the cost-effectiveness of the alternate funding approach and also cannot compare the income of physicians paid through these arrangements to the income of physicians performing similar work but paid under the traditional fee-for-service arrangement.
- The alternate funding arrangement contracts generally do not contain measures by which the Ministry can assess the extent to which the objectives necessitating the alternate funding arrangement, such as improving patient access and advancing innovation in medicine, have been achieved.
- There are numerous types of payments and various premiums that specialists can earn, making contract- and payment-monitoring difficult for the Ministry. For example, for academic services (including training new physicians and conducting research), there were up to nine different categories of payments under AHSC contracts and up to 14 categories under academic comprehensive contracts.
- Ten AHSCs received "specialty review funding" totalling $19.7 million in the 2009/10 fiscal year as an interim measure to alleviate immediate human resource challenges in five specialty areas. However, similar temporary or interim funding has been given annually since 2002.
- In May 2007, the Ministry obtained permission from 234 northern specialists to collect information on each physician's income from provincial government–funded sources. The Ministry paid these physicians $15,000 each.
- As a means to monitor whether specialists funded under academic contracts have met their contract obligations, the Ministry provided them with a checklist to self-evaluate their performance in this regard. However, the Ministry does not request the results of this self-evaluation, and it does only minimal other monitoring of these specialists to ensure that they are providing the level of service outlined in their contracts.

We also noted instances where the Ministry chose not to recover its overpayments to physicians. Our observations in this regard included the following:

- The Ministry has a good process in place to identify overpayments to emergency department physicians and found $3.9 million in overpayments from the 2005/06 fiscal year to the 2009/10 fiscal year. However, even though the physicians at these emergency departments worked fewer hours than they were paid for, the Ministry did not attempt to recover any of the overpaid funds because it was concerned this would negatively affect patient wait times at these emergency departments.
- In April 2008, the Ministry paid over $15 million to 292 physicians who signed a document indicating their intent to join a northern specialist alternate funding arrangement. However, 11 of the physicians, who were paid a total of $617,000, did not subsequently join an alternate funding arrangement yet were allowed by the Ministry to keep the funding.

- The Ministry's review of service levels provided by AHSCs during the 2007/08 and 2008/09 fiscal years indicated that 40% generally had at least one specialty area that did not meet the contracted service-level requirements. However, no attempt was made to recover these overpayments nor was any adjustment to future funding levels made.

## OVERALL MINISTRY RESPONSE

The Ministry welcomes the report from the Office of the Auditor General regarding alternate funding arrangements for specialist physicians. These arrangements were founded to address specific concerns, including sustaining or improving access to health-care services for all Ontarians regardless of income, geography, or other barriers to access. In this regard, the arrangements were often aimed at communities, services, and programs where the volume-driven fee-for-service model did not fit. To this end, the Ministry funds the majority of emergency departments, hospital-based northern specialists, and medical training, research, and innovation activities through alternate funding arrangements. The anticipated benefits of the arrangements are timely patient access to health services and reduced wait times, a reduction in travel costs, decreased morbidity and mortality, a reduction in hospitalizations and hospital-related costs, and a new generation of well-trained specialist physicians.

The Ministry appreciates the comments from the Auditor General about ongoing cost/benefit analyses of the alternate funding arrangements. Although the cost of these arrangements is offset in part by a reduction in fee-for-service payments, the measure of cost-effectiveness is not only as compared to fee-for-service, but must also take into account benefits associated with a range of health determinants over the long term, including access to care. The Ministry supports the need for further research in this area.

The Ministry also supports the need for clearly defined reporting expectations and meaningful performance measures and targets. As the Auditor General has noted, the Ministry has made progress on implementing standard contracts to reduce the complexity among agreement types. Furthermore, the Ministry is engaged in continuing this process through continual review and modernization of existing agreements to ensure that existing agreements:

- continue to address the Ministry's objectives;
- are in compliance with established protocols and processes;
- include appropriate performance monitoring and reporting provisions; and
- include appropriate, timely, and documented corrective actions.

# Detailed Audit Observations

## OVERVIEW

Like many other Canadian jurisdictions, Ontario has alternate funding arrangements for specialists. The Ministry's goals for these arrangements include:

- maintaining and enhancing the academic activities of physicians (for example, training medical students and conducting research);
- enhancing income predictability and stability for physicians; and
- increasing the recruitment and retention of physicians in underserviced areas.

At the time of our audit, there were 10 types of specialist alternate funding arrangements, including arrangements for academic specialists; emergency department physicians; and specialists working in Northern Ontario. A specialist arrangement may fund an individual department in one hospital, or it may cover a range of services provided by all the physicians at a hospital. Prior to 2004, groups of physicians contacted the Ministry

to establish and participate in alternate funding arrangements. These arrangements represent over 80% of participating physicians. Since 2004, groups of physicians may initially contact either the Ministry or the Ontario Medical Association to propose new arrangements, or arrangements may be proposed directly by the Ontario Medical Association to the Ministry. Arrangements are then negotiated between the Ministry and the Ontario Medical Association. Physician groups generally have a governing organization (sometimes called a governance group), whose responsibilities include deciding how payments to the group will be allocated among participating physicians.

The specialist alternate funding arrangements are primarily managed by the Specialist Physician Contracts Unit in the Ministry's Negotiations Branch. Other branches within the Ministry are also involved in helping administer the contracts. These include the Financial Management Branch, which is responsible for processing physician payments and conducting financial forecasting and reporting; the Health Data Branch, which is responsible for collecting statistics relating to physician counts, conducting trend analyses, and calculating certain payments; the Registration and Claims Branch, which is responsible for processing physician registrations; and the Health Solutions Delivery Branch, which is responsible for developing information systems to support new types of payments or changes in payment rates.

## CONTRACTING WITH SPECIALISTS

For most of the arrangements, either the Ontario Medical Association or a specialist group that was interested in receiving compensation for services not funded through fee-for-service payments approached the Ministry requesting that an alternate funding arrangement be established, such as for training and research. They may also have requested funding for other reasons, such as increasing physician income when patient volume in a region is too low to provide a full-time specialist with a fee-for-service income level similar to what he or she would earn in other parts of the province. The Ministry generally is not approached about establishing an alternate funding arrangement for specialist groups that do not have concerns about the equity of their compensation levels, such as ophthalmologists, cardiologists, and radiologists.

The Ministry indicated that it reviews submitted proposals outlining why a physician group should receive alternate funding; compares the costs of the proposed alternate funding arrangement with the historical fee-for-service costs; and assesses the proposed benefits, such as improved patient access to care. We requested the Ministry's analyses for various specialist alternate funding arrangements, including arrangements for emergency departments, Academic Health Science Centres (AHSCs), and northern specialists, but it was unable to locate its analyses for these funding arrangements. However, the Ministry was able to locate a cost estimate prepared by the Ontario Medical Association for AHSCs. Based on this estimate, payments were expected to increase by 33%. As well, the Ministry was able to locate its cost estimates for two recent emergency department contracts. These estimates indicated that payments for physician services were expected to increase by 32% and 60%, respectively. The Ministry indicated that the benefits of these arrangements were expected to include improved patient access to care.

If the Ministry decides to pursue the alternate funding arrangement, it begins negotiations, which are generally with the specialist group of physicians, the Ontario Medical Association, and often the hospital at which the specialists provide services. In the case of specialists who train medical students, a university may also be part of the negotiations. As a result of these negotiations, the Ministry has developed standard contracts for most of the alternate funding arrangements, including those involving emergency departments, AHSCs, and northern specialists. For the few non-standard funding arrangements (for example, academic comprehensive agreements, which were developed

prior to the standardized AHSC contracts), each specialist group receiving funding under the same type of plan negotiates a unique contract with the Ministry. As of March 31, 2011, the Ministry had almost 250 agreements with specialist groups, as shown in Figure 2. The Ministry informed us that it intends to develop standard contracts for all plans in the future.

The contracts generally stipulate the amount of funding the specialists will receive, the service levels that the specialists must provide, recruitment and retention mechanisms for new specialists, and information that specialists must report to the Ministry. As well, the contracts usually include objectives such as improving patient access; supporting the clinical training needs of medical students, physicians, and other health-care providers; and advancing innovation in medicine. However, while the AHSC arrangement has more than 20 performance measures, the other arrangements generally do not have any. The Ministry had not used the measures in the AHSC contract to determine to what extent the objectives necessitating the alternate funding arrangement had been achieved. Further, the measures in the AHSC arrangement did not include the number of patients seen or wait times to access care. These measures would assist the Ministry in assessing whether the service levels and overall intent of the arrangements were being met.

Most specialist physicians who participate in an alternate funding arrangement are required to sign a form to indicate their acceptance of the contract's terms. By signing such a form, a physician is agreeing to, among other things, provide services in accordance with the contract and not bill the Ontario Health Insurance Plan (OHIP) for these services except as provided for under the contract. Some contracts require participating physicians to sign the form before they begin to provide services; other contracts state that they must sign the form within 30 days of beginning to provide services; and still other contracts are silent regarding when the forms must be signed. For contracts tested where we would expect to have seen physician-signed forms, we found that only 30% of physicians signed consent forms before they began providing services. An additional 42% signed consent forms after they began providing services, and the Ministry did not have consent forms for the remaining 28%. Without a signed consent form, there is a risk that physicians may not fully understand their obligations and, for example, not provide the level of patient services required under the contract.

**Figure 2: Number of Contracts by Agreement Type, as of March 31, 2011**

Source of data: Ministry of Health and Long-Term Care

| Agreement Type | # of Contracts |
|---|---|
| academic comprehensive | 3 |
| Academic Health Science Centres | 18 |
| emergency departments | 134 |
| northern specialists | 23 |
| other | 70 |
| **Total** | **248** |

## RECOMMENDATION 1

To help ensure that compensation arrangements for specialists meet the Ministry of Health and Long-Term Care's goals and objectives in a financially prudent manner, the Ministry should:

- assess and document the anticipated costs and benefits of each alternate funding arrangement, compared to the standard fee-for-service compensation method, before entering into a formal agreement;
- incorporate specific performance measures into the contracts, such as the number of patients to be seen or the wait times to access care, to enable the Ministry to periodically assess what benefits are received for the additional cost of the arrangement; and
- require physicians to sign that they agree to the terms of the contract before commencing participation in an alternate funding arrangement.

## MINISTRY RESPONSE

The Ministry supports this recommendation, and as it moves forward to negotiate or renegotiate alternate funding arrangements it will work toward full compliance with this recommendation.

In recent years, alternate funding arrangements have been negotiated as part of the overall Physician Services Agreement discussions with the Ontario Medical Association. The alternate funding arrangements negotiated and implemented as part of this process are developed to ensure that the goals and strategic priorities of the Ministry and the Ontario government are met. These goals and priorities include ensuring access to high-quality health care for all Ontarians and providing specialist services in underserviced communities. The Ministry will continue to compare the initial cost of each alternate funding arrangement to the fee-for-service compensation method before entering into a formal agreement.

The Ministry supports the principle of incorporating specific performance measures into the arrangements and is committed to improving how it demonstrates measurable results as it meets its goals and priorities in a cost-effective manner. All agreements negotiated or renegotiated with specialists will have the roles, responsibilities, accountability relationships, and obligations of all parties clearly defined and documented. In addition, the Ministry will work toward implementing reporting expectations with meaningful performance measures and targets.

The Ministry requires all participating physicians to sign an agreement before commencing participation in an alternate funding arrangement and will ensure full compliance with this obligation.

## PAYING SPECIALISTS

Total ministry payments under both fee-for-service and alternate funding arrangements to all specialists and emergency department physicians increased by over 25% from $5 billion in the 2006/07 fiscal year to over $6.3 billion in the 2009/10 fiscal year, the most recently available data for total payments to these groups. Somewhat similarly, payments made under alternate funding arrangement contracts for specialists and emergency department physicians increased by over 30% during the same period, from more than $800 million in the 2006/07 fiscal year to almost $1.1 billion in the 2009/10 fiscal year.

Payments to specialists under the alternate funding arrangements are complicated, because there are numerous types of payments and various premiums that specialists can earn. Figure 3 outlines selected types of payments.

Figure 4 provides further information about how physician compensation is determined under selected specialist alternate funding arrangements.

### Academic Physicians

Academic specialists represent more than half of the specialists participating in alternate funding arrangements. There are two main arrangements for academic specialists:

- Academic Health Science Centres (AHSCs)—a standardized arrangement introduced in 2003 to support academic physicians working at AHSCs, which are formed through an agreement between a university with a medical school, a hospital where medical students are trained, and physicians that work at both. In the 2009/10 fiscal year, 3,700 physicians received $242 million under this arrangement.
- Academic comprehensive—unique agreements established prior to the introduction of the AHSC arrangements involving three hospitals and the associated universities,

**Figure 3: Selected Types of Payments under Specialist Alternate Funding Arrangements**

Prepared by the Office of the Auditor General of Ontario

| Type of Payment | Description |
|---|---|
| base funding | A lump sum paid to specialist groups for providing a collection of services |
| fee-for-service | Physicians bill OHIP and are paid an established fee for each service provided to a patient |
| shadow billing | Physicians who receive base funding can bill OHIP and be paid a percentage of the established fee for each service provided to a patient |
| premiums | Additional payments to physicians to provide specific services, such as patient care on weekends |
| administration | Amounts paid to specialist groups for administering alternate funding arrangements |

to support academic physicians. In the 2009/10 fiscal year, 1,200 physicians received $268 million under this arrangement.

Figure 4 highlights some of the significant differences between these two payment arrangements.

Up to nine types of payments were made under each AHSC contract, and up to 14 types of payments were made under each academic comprehensive contract, including payments for the items shown in Figure 3. Based on our testing of these payments primarily in the 2009/10 fiscal year, we noted that:

- The Ministry did not have documentation to support whether the base funding amount paid under the three academic comprehensive contracts in the 2009/10 fiscal year was accurate. A significant portion of the base funding amount is based on physicians' highest 12 consecutive months of OHIP billings before joining the alternate funding arrangement. We noted that for 2009/10, base payments to one hospital exceeded the contract amount by $2.1 million. Ministry staff informed us that the majority of the difference was likely due to physicians entering and leaving the academic group. However, the Ministry had no information on who had joined or left the groups, which would be needed to substantiate the amount that was paid.
- Funding to recruit recently graduated physicians or physicians new to the province began under the academic comprehensive contracts in the 2008/09 fiscal year. However, one academic physician group was already receiving $575,000 annually for the recruitment of physicians, having negotiated that payment as part of its base funding. This physician group received additional funding for recruitment activities after the recruitment funding was introduced in 2008/09, including an additional $495,000 in the 2009/10 fiscal year, as the funding was available to all groups including the group that was already receiving recruitment funding.
- In the 2007/08 fiscal year, $8.5 million in recruitment funding for AHSC physicians was allocated to their governance groups to distribute as they saw fit. Based on reports received by the Ministry, $3.2 million of this funding was spent on recruiting physicians. The Ministry had no information on how the remaining $5.3 million was spent. Similar issues were not noted in subsequent years.
- Ten hospitals received "specialty review funding" totalling $19.7 million in the 2009/10 fiscal year to, according to the Ministry, "serve as an interim measure to alleviate immediate human resource challenges" in five specialty areas. Although it was indicated that it was an "interim" measure, similar temporary funding actually had been in place annually since 2002. The Ministry informed us that a formal review was done in 2002 that determined that there was a funding shortfall in these five specialty areas, but the Ministry was unable to provide any documentation relating to this

## Figure 4: Payment Methods for Selected Specialist Alternate Funding Arrangements

Prepared by the Office of the Auditor General of Ontario

| Arrangement/ Agreement Type | Start Date | How Specialists Are Paid | Additional Funding |
|---|---|---|---|
| **Academic Arrangements** | | | |
| Academic Health Science Centres (AHSCs) | 2003 | *Base funding + fee for service (FFS)*<br>AHSCs are formed through an agreement between a university with a medical school, a hospital where medical students are trained, and physicians who work at both.<br>These agreements provide AHSCs with funding to pay physicians who teach, research, recruit, and provide clinical services to patients. Base funding is provided for all activities, excluding clinical services, and an additional amount (called clinical repair funding) is provided to close the gap in compensation between academic and non-academic physicians.<br>Physicians also bill OHIP on an FFS basis for clinical services provided to patients. 40% of the FFS funding is paid directly to physicians; the remaining 60% is paid to the group that governs the AHSC, to be distributed at the group's discretion. The Ministry considers these to be regular FFS payments, not alternate payment amounts. | Funding of $140,000 to $835,000 per year is provided for administration costs (based on a percent of funding they receive for certain activities, including clinical services and training medical students). |
| academic comprehensive | 1990 | *Base funding + shadow billing*<br>These agreements, which are used by three hospitals, predate the current AHSC standard contract. Base funding is provided for teaching, researching, and providing clinical services to patients. Also, physicians in two of the three hospitals shadow bill for clinical services at 10% of the FFS claim value. | Funding for additional administration costs is provided under one contract only, in the amount of $400,000 per year. |
| **Emergency Department Arrangements** | | | |
| workload model | 2001 | *Base funding + shadow billing*<br>The workload model funds larger hospitals (i.e., those that have over 25,000 patient visits to the emergency department annually and require coverage by more than one on-duty physician). Base funding is determined by the annual volume of patients in the previous year as well as patient acuity (i.e., the urgency of care required). Services are also shadow-billed at 25% of the FFS claim value. | Under both emergency department models, funding of $20,000 to $50,000 per year (based on patient volume) is provided for administration costs.<br>Recruitment and mentorship programs are available that provide funding for each eligible new recruit. Similar funding is available to emergency department physicians paid through FFS. |
| 24-hour model | 1999 | *Base funding + shadow billing*<br>The 24-hour model funds smaller hospitals (i.e., those that have fewer than 25,000 patient visits to the emergency department annually and therefore need only one on-duty physician). There are 10 funding levels, with base funding for each level determined by the number of patients visiting the emergency department in the previous calendar year. Physicians can also shadow bill OHIP, and are paid at 25% of the FFS claim value. | |
| **Northern Specialist Arrangement** | | | |
| Northern Specialist Alternate Payment Plan | 2008 | *Base funding + fee for service (FFS)*<br>Each physician receives $55,000 plus 30% of the physician's historical FFS billings, which are converted to "stable" or base funding. This payment is intended to assist in stabilizing clinical services and the retention of existing physicians in the northern centres.<br>In addition, participating physicians bill OHIP, and are paid 70% of the FFS claim value. | Funding of $15,000–$75,000 per group for the first year of funding and $5,000–$72,000 per group every year after for administration costs (based on the number of physicians in the group). There may be an additional annual payment of up to $15,000 to acknowledge the remoteness of some communities. |

review. The Ministry also indicated that the funding has been periodically reviewed. The most recent review was in 2009 and involved a two-day consultation with funding recipients. The Ministry concluded on the basis of discussions with the recipients that the funding was having a positive impact and would continue unchanged until further review.

- Clinical repair funding provides academic physicians with additional income to make their income levels comparable to those of non-academic physicians, who generally have time to see and bill for more patients. Since its introduction in the 2007/08 fiscal year, clinical repair funding has been calculated annually based on what similar non-academic specialists billed OHIP in the 2006/07 fiscal year. However, the Ministry had no documented analysis of whether the clinical repair funding amount in the 2010/11 fiscal year made the income of academic specialists reasonably comparable to non-academic specialist incomes. The Ministry indicated that it commenced a review of AHSC funding in 2010, which includes a review of clinical repair funding. The Ministry expects to complete this review by December 2011.

## Emergency Department Physicians

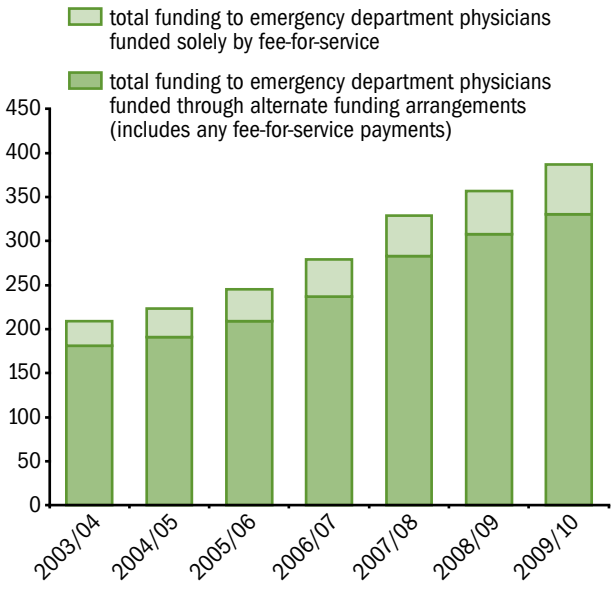
Funding to the province's more than 145 emergency departments is intended to provide for around-the-clock emergency services. Between the 2003/04 and 2006/07 fiscal years, total ministry funding for emergency department (ED) physician services increased by almost 35%, as shown in Figure 5. Similarly, from the 2006/07 fiscal year to the 2009/10 fiscal year, payments for ED physician services also increased by almost 40% in total, although the number of physicians who worked in emergency departments increased by only 10%, and the number of patient visits to emergency departments increased by only 7% during the same period. The Ministry stated that 10 additional emergency departments joined an alternate funding arrangement during this time and that alternate funding arrangements usually result in increased payments to physicians. The Ministry also indicated that the primary goals of the ED alternate funding arrangement were to ensure that emergency departments remain open 24 hours a day, seven days a week, and maintain a stable workforce of physicians.

For the 2009/10 fiscal year, payments for the services of ED physicians participating in an alternate funding arrangement consisted primarily of $268 million in base funding with shadow billing (that is, physicians are paid 25% of the established fee-for-service amount for submitting data to OHIP on patient services provided) as well as additional premiums and other payments totalling $47 million.

Funding for ED physicians participating in the workload model, under which more than one physician may be working in the emergency department at the same time, is based on patient acuity (that is, the urgency of care required by the patient) as well as on patient volume in the previous year. The Ministry inputs this information into a formula

**Figure 5: Ministry Funding for All Emergency Department Physician Services, 2003/04–2009/10 ($ million)**

Source of data: Ministry of Health and Long-Term Care



to determine the number of hours ED physicians are required to work to meet patient needs. The formula was developed based on research commissioned by the Ministry. The Ministry uses these hours and an hourly rate to determine the funding to be provided annually to each group of ED physicians. The Ministry indicated that the established hourly rate was initially developed in the 1999/2000 fiscal year by a working group consisting of representatives from the Ministry, the Ontario Medical Association, and the Ontario Hospital Association.

The Ministry indicated that the current funding levels for ED groups under the 24-hour model (where only one ED physician is on duty at a time) were set in the 2006/07 fiscal year, based on negotiations between the Ministry, the Ontario Medical Association, and the Ontario Hospital Association. Since then, funding for ED groups under the 24-hour model has generally been based on patient volumes for the previous calendar year.

We noted that overpayments to ED physician groups were not being recovered. For example:

- Under the Ministry's contract with physicians participating in the workload model, the Ministry is to recover funds if the ED group provides fewer hours of work than determined under the Ministry's formula; conversely, the Ministry must make an additional payment if the ED group provides more hours, whether due to the volume or acuity of patients increasing. When we reviewed reconciliation summaries prepared by the Ministry for the five-year period from the 2005/06 fiscal year through the 2009/10 fiscal year, we identified Ministry overpayments totalling $3.9 million. These overpayments were made to 24 ED groups, with 10 ED groups receiving overpayments in more than one year. The Ministry indicated that it had chosen not to recover the overpayments because the recovery could negatively affect patients' access to ED services or increase ED wait times.
- When we reviewed Ministry payments made in the 2009/10 fiscal year (the last full year for which data were available at the time of our audit) to ED groups funded under the 24-hour model, we noted that over 35% of the ED groups sampled received more funding than stipulated in their contract with the Ministry. Excess funding in 2009/10 amounted to over $400,000, none of which was recovered by the Ministry. The Ministry indicated that the ability of these EDs to provide physician coverage 24 hours a day, seven days a week, would have been compromised without this additional funding.

## Northern Specialist Physicians

Alternate funding arrangements for northern specialists were introduced effective April 1, 2008. For the 2009/10 fiscal year, 280 physicians received payments totalling $39 million under the northern specialist alternate funding arrangements. This included about $5 million primarily related to base funding for the prior year.

The alternate funding arrangements for northern specialists were determined as a result of negotiations with the Ontario Medical Association, similarly to other alternate funding arrangements. However, unlike negotiations for other funding arrangements, special payments were made to northern specialists during the negotiation process. Specifically:

- In May 2007, the Ministry paid $15,000 each to 234 physicians, who gave the Ministry and Ontario Medical Association permission to collect information on the physicians' income from universities, hospitals, and the Ministry, through fee-for-service billings, for the purpose of negotiating the northern specialist alternate funding arrangement.
- In April 2008, the Ministry paid over $15 million in total to 292 physicians who signed a document indicating that they planned to join a northern specialist alternate funding

arrangement, effective April 1, 2008. The Ministry informed us that this money was funding for the previous fiscal year (which ended March 31, 2008) and was paid to these physicians in addition to their regular fee-for-service earnings through OHIP. The amount paid ranged from $20,000 to $70,000 per physician, with most physicians receiving $55,000. The document physicians signed indicated that the money was to be returned to the Ministry if the physician did not join a northern specialist alternate funding arrangement. We noted that 39 physicians, who collectively received over $1.1 million, did not join a northern specialist alternate funding arrangement. Contrary to the document signed, the Ministry subsequently allowed these physicians to keep the money as long as they joined any type of alternate funding arrangement and continued to practise in Northern Ontario. However, 11 of these physicians did not join any type of alternate funding arrangement. The Ministry did not recover any of the $617,000 paid to these 11 physicians.

## RECOMMENDATION 2

To better ensure that payments made under alternate funding arrangements among similar specialist groups are in accordance with the underlying contracts, the Ministry of Health and Long-Term Care should:

- simplify the numerous different types of payments under the academic contracts; and
- review situations where additional funding is consistently being provided or where overfunding or duplicate payments have occurred in order to determine whether the funding should be adjusted or recovered.

## MINISTRY RESPONSE

The Ministry supports this recommendation. As the Auditor General has noted, payments to specialists under the alternate funding arrangements are complicated, because there are numerous types of payments and various premiums that specialists can earn. The Ministry agrees with the Auditor General's observation that there is an opportunity to simplify or reduce the number of payments, particularly when they are similar to or have outlived their necessity to be distinguished from base funding.

The Ministry is also reviewing practices with respect to recoveries; however, the Ministry notes that there may be cases, such as for the emergency department alternate funding arrangements, where pursuing a recovery could jeopardize the ability of some emergency departments to provide services 24 hours a day, seven days a week.

## MONITORING ALTERNATE FUNDING ARRANGEMENTS

We reviewed the Ministry's monitoring of alternate funding arrangements with academic physicians and emergency department physicians.

The fee-for-service payment method encourages physicians to see as many patients as possible, because they get paid based on services provided. However, most alternate funding arrangements do not compensate physicians based solely on the volume of patient services provided. As a result, it is important that alternate funding arrangements with physicians be properly monitored to ensure that specialists maintain a minimum level of patient services. As well, it is important that the Ministry track the costs of each alternate funding arrangement and evaluate whether the alternate funding arrangements are meeting the Ministry's health-care goals in a cost-effective manner.

Shadow billing occurs when physicians participating in certain alternate funding arrangements (for example, academic comprehensive and emergency department) submit data to OHIP on

patient services provided. These physicians are paid a percentage (which varies by alternate funding plan) of the established amount that fee-for-service physicians receive for providing these services. Shadow-billing data can be used to assess the level of services provided by specialists participating in alternate funding arrangements and is used by at least one other Canadian jurisdiction for such purposes. However, the Ministry informed us that it has not analyzed shadow-billing claims to determine the number of patients seen or the clinical services provided.

Further, under the Academic Health Science Centre (AHSC) contracts, physicians can bill 100% of the fee-for-service claim value for clinical services provided, on top of the other amounts paid in the contract. Similarly, under the northern specialist contracts, physicians can bill 70% of the fee-for-service claim value, on top of the other amounts paid. The Ministry does not track the total fee-for-service amounts paid under either of these arrangements. Therefore it does not include these payments, which we would expect to be significant, when it determines the total amounts paid under the AHSC and northern specialist arrangements. Without this information, the Ministry does not know the total amounts paid to physicians under these arrangements. In addition, because a considerable proportion of the payments under the AHSC contracts goes to the governing group for distribution to the physicians, instead of directly to individual physicians, the Ministry does not know the total amount of compensation received by each physician participating in an AHSC and therefore the reasonableness of the amounts cannot be periodically assessed.

The Ministry acknowledged that this information would be useful and advised us that the Institute for Clinical Evaluative Sciences (ICES) is currently performing a review of physician compensation by specialty and it expects to receive a copy of the report from ICES by spring 2012. The Ministry also indicated that it commenced a review of AHSC funding, including physician-level funding information, which it expects to complete in December 2011.

Because patient volume and acuity form the basis of funding for emergency department physicians, the Ministry obtains information about both from emergency departments funded through alternate funding arrangements. We found that the Ministry made use of this information to identify over- and underpayments to emergency departments. As well, the Ministry had a process for preventing excess fee-for-service billings in certain circumstances, and received information on projected staffing shortages in emergency departments.

However, the Ministry's monitoring of the academic contracts was not effective. The contracts for academic physicians paid through alternate funding arrangements require that their governance groups submit numerous reports, such as an annual business plan, audited financial statements, a financial report, and a human resource report. Although we found that the Ministry received much of this information, it was not reviewing or analyzing it.

We concluded that the Ministry has little assurance that specialists provided the service levels outlined in their contracts. The Ministry informed us that it performs minimal direct monitoring as it expects specialists funded under academic contracts to meet their contract obligations, such as providing minimum hours of service or spending a minimum percentage of their time seeing patients. For example:

- There are three academic comprehensive arrangements in place, all of which require that the physicians in the group collectively work a minimum number of full-time hours. Two of the physician groups with these alternate funding arrangements submit reports to the Ministry that contain information that can be used to verify the total number of physician hours worked. The third hospital did not submit such information and the Ministry had not followed up to request the information.
- Under the academic comprehensive contracts, specialists are also required to provide a

minimum level of clinical patient services. For example, specialists working under one academic comprehensive contract are required to allocate 75% of their time to clinical services and the remainder to teaching, research, and administrative activities. However, at the time of our audit, the Ministry informed us that it was not obtaining information on whether the physicians were allocating 75% of their time to clinical services because this was considered a guideline, not a requirement. In another example, specialists working under another academic comprehensive agreement are required to provide a minimum of 33 hours of clinical services per week. Although the Ministry received some information annually on how physicians spent their time at work, it did not receive any information on how many hours of clinical service the physicians actually provided. The Ministry indicated that it does not set the hours of work for these physicians, and therefore it is considering the use of other service-level indicators, such as those in the AHSC contracts, in the future.

- Specialists working under AHSC contracts are required to provide a minimum level of clinical services, including seeing a minimum number of patients. The AHSC agreements state that if the physicians' services fall below an established level for each specialty, the Ministry may reduce the specialists' funding for that year. In April 2010, the Ministry reviewed information on the service levels achieved by the AHSCs for the 2007/08 and 2008/09 fiscal years and found that although over 60% of the AHSCs had met service-level requirements in all their specialty areas, the remaining 40% generally had at least one specialty area that did not meet the service-level requirements specified under the contract. No adjustment to future funding levels was made, nor was any funding recovered by the Ministry.
- The Ministry promotes self-monitoring for physicians participating in an AHSC arrangement. In July 2010, the Ministry sent letters to the governance groups of the AHSC alternate funding arrangements asking them to perform a self-assessment using a checklist provided. This checklist was developed by the Ministry to help AHSCs assess whether they are meeting their obligations under their alternate funding agreements. The checklist covered areas such as governance, provision of services, and reporting requirements. The checklist asked whether processes were in place to monitor whether direct patient services and on-call services were provided. However, there was no actual requirement for the AHSCs to complete the self-assessments or to return completed self-assessments to the Ministry. The Ministry indicated that in future years it would be requesting confirmation that the AHSCs had completed the assessment. To ensure that the AHSCs take appropriate action on issues noted in the checklist, the Ministry is also considering whether or not to request the results of the assessment in the future.

We also noted that the Ministry does not periodically review whether its overall goals and objectives for specialist alternate funding arrangements—such as improving patient access; supporting the clinical training needs of medical students, physicians, and other health-care providers; and advancing innovation in medicine—are being met.

## RECOMMENDATION 3

To better ensure that Ontarians have access to specialist physician care, consistent with the overall objective of alternate funding arrangements, the Ministry of Health and Long-Term Care should monitor whether specialist groups are providing patient care and other services in accordance with their contracts.

Further, to ensure that the benefits of the specialist alternate funding arrangements outweigh the costs, the Ministry should track the full costs of each alternate funding arrangement,

including total fee-for-service billings paid to physicians, either directly or indirectly, and use this information to periodically review whether its overall goals and objectives for such arrangements are being met in a cost-effective manner.

## MINISTRY RESPONSE

The Ministry supports this recommendation and the inclusion of appropriate performance measures in all alternate funding arrangements. Further, the Ministry agrees that the specialist arrangements must be clear and detailed and that they must be actively monitored and reviewed in order to ensure that physician groups are providing patient care and other services in accordance with their contracts. Work is under way to develop regular reporting of all physician payments under each agreement. An enhanced internal monitoring process has been developed and will be implemented in the near future. This will allow the Ministry to undertake regular reviews of the clinical services provided by specialists and to undertake periodic costing analyses.

The Ministry is currently evaluating specialist payments under the Academic Health Science Centre and academic comprehensive arrangements for the 2009/10 and 2010/11 fiscal years, which will also enable the Ministry to assess the reported level of clinical services and academic activities for both physician groups and individual physicians.