

Chapter 3

Section 3.06

Ministry of Health and Long-Term Care

Funding Alternatives for Family Physicians

Background

Ontario residents are eligible for provincially funded health coverage under the Ontario Health Insurance Plan (OHIP). The traditional method of compensating primary-care physicians (also known as family physicians) for providing medical services has been to pay them a standard fee for each service performed, known as OHIP fee-for-service payments. The medical services covered and the standard fees payable are detailed in OHIP's Schedule of Benefits.

Funding alternatives (known as alternate funding arrangements) for family physicians commenced years ago, but over the last decade the Ministry of Health and Long-Term Care (Ministry) has significantly increased its use of these arrangements in order to, among other things, improve patient access to care and provide income stability for physicians. Under many of the arrangements, instead of receiving a fee for each service performed, physicians are paid an annual fee (called a capitation fee) to provide any of a specific list of services to each patient who agrees to see the physician as his or her regular family physician. (Such patients are considered to have “enrolled with” the physician.) Services not covered by the capitation fee, including services provided to patients who are not enrolled, may generally be billed on a fee-for-

service basis. By 2011, there were 17 types of alternate funding arrangements for family physicians, each with a different payment structure; 12 of these arrangement types were for physicians who treat a specialized population, such as maternity and palliative patients.

Alternate funding arrangements are generally established and modified by the Physician Services Agreement between the Ministry and the Ontario Medical Association, which bargains on behalf of physicians in Ontario. This agreement—which has been negotiated every four years, starting in 2000—details the services that physicians are required to provide and the compensation that the province will pay for the services rendered.

By the end of the 2009/10 fiscal year, more than 7,500 of the province's almost 12,000 family physicians were participating in alternate funding arrangements, and more than nine million Ontarians had enrolled with these physicians. Total funding to all family physicians increased by 32%, from \$2.8 billion to \$3.7 billion, between the 2006/07 and 2009/10 fiscal years. Of the \$3.7 billion in total payments made to the province's family physicians in the 2009/10 fiscal year, more than \$2.8 billion was paid to physicians participating in alternate funding arrangements, with \$1.6 billion of this amount related to non-fee-for-service payments, such as annual capitation payments.

Audit Objective 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 family physicians, and the audit in Section 3.07 focused on those for specialists. Our audit objective was to assess whether the Ministry has implemented systems and processes to monitor and assess whether alternate funding arrangements provide Ontarians with timely access to family physicians in a cost-effective manner. Ministry senior management reviewed and agreed to our audit objective and associated audit criteria.

Given the number of different alternate funding arrangements available for family physicians, our audit focused primarily on the Family Health Group (FHG) and Family Health Organization (FHO) arrangements, and to a lesser extent on the Family Health Network (FHN) arrangement. In the 2010/11 fiscal year, these three types of arrangements accounted for over 90% of family physicians participating in an alternate funding arrangement and over 90% of enrolled patients.

Our audit work was conducted primarily at the Kingston and Toronto offices of the Ministry's Primary Health Care Branch. In conducting our audit, we reviewed relevant documents, analyzed information, interviewed appropriate ministry staff, and reviewed relevant research from Ontario and other jurisdictions. In addition, we employed a number of computer-assisted audit techniques to analyze patient-enrolment data, medical-claims data, and physician-registration records. As well, we reviewed and, where warranted, relied on the work completed by the Ministry's internal audit service team.

Summary

The Ministry has made progress in its goal of increasing the number of Ontarians who have a family physician by encouraging physicians, through financial incentives, to switch from the traditional fee-for-service compensation model to alternate funding arrangements (mostly involving multi-physician practices). More than 90% of family physicians participating in these arrangements receive payments based on how many enrolled patients they have, as well as additional incentives and bonuses not available to physicians paid under the traditional fee-for-service model. Payments to family physicians through these arrangements more than doubled, from about \$750 million in the 2006/07 fiscal year to over \$1.6 billion in the 2009/10 fiscal year. During this time, the number of physicians participating in alternate funding arrangements increased by 11%, yet the number of patients enrolled in participating physicians' practices increased more substantially, by 24%, to more than nine million Ontarians.

Although the Ministry intended alternate funding arrangements to be more generous than the traditional fee-for-service model, the Ministry has not tracked the full cost of each alternate funding arrangement since the 2007/08 fiscal year. At that time, most family physicians participating in these arrangements were being paid at least 25% more than their counterparts compensated on a fee-for-service basis. In 2009/10, 66% of family physicians participated in an alternate funding arrangement, and these physicians received 76% of the total amount paid to all family physicians. Although the Ministry has some initiatives under way, it has not yet conducted any formal analysis of whether the expected benefits of these more costly alternate funding arrangements have materialized.

The types of payments made under alternate funding arrangements are numerous and complicated, which has made it challenging for the Ministry to monitor physician compensation paid

through these arrangements or the extent to which the physicians have actually provided services required by their particular arrangements. The Ministry needs better information to determine whether the alternate funding arrangements are providing Ontarians with improved access to family physicians in a cost-effective manner and to be well prepared for the upcoming negotiations with the Ontario Medical Association in 2012.

Some of our more significant observations include the following:

- Along with alternate funding arrangements, the Ministry has established other initiatives to help people find a family physician. The Ministry estimated—on the basis of a survey it commissioned—that these initiatives have resulted in almost 500,000 more Ontarians having a family physician in 2010 than in 2007. However, the survey also found that patients generally indicated that the wait times to see a physician had not changed significantly over the last few years.
- Based on data from the 2007/08 fiscal year (the latest available at the time of our audit), family physicians paid through the Family Health Group (FHG) and the Family Health Organization (FHO) alternate funding arrangements earned on average \$376,000 to \$407,000 (from which they pay overhead expenses), which was over 25% more than what, on average, family physicians were being paid under the traditional fee-for-service model.
- The Ministry had adequate controls to ensure that no patient was enrolled with more than one family physician and was generally up to date on processing patient enrolments and de-enrolments with physicians.
- Of the 8.6 million patients enrolled with either an FHO or an FHG, 1.9 million (22%) did not visit their physician's practice in the 2009/10 fiscal year, yet the physicians in these practices received a total of \$123 million just for having these patients enrolled. Further, almost half of these patients visited another physician, and OHIP also paid for those visits.
- Although many more Ontarians are enrolled with multi-physician practices under the new alternate funding arrangements than in the 2006/07 fiscal year, the wait time to see a family physician if they become sick has not changed as a result. Based on ministry survey results, while more than 40% of patients got in to see their physician within a day, the rest indicated that they had to wait up to a week or longer.
- The annual capitation fee for each enrolled patient under an FHO arrangement can be 40% higher per patient than the capitation fee for patients enrolled under a Family Health Network (FHN) arrangement, because almost twice as many services are covered under the FHO arrangements. Nevertheless, in the 2009/10 fiscal year, 27% of all services provided to FHO patients were not covered by the arrangement, and the Ministry paid an additional \$72 million to the physicians for providing these services. Thirty percent of these services were for flu shots and Pap-smear technical services, yet the Ministry had not assessed whether it would be more cost-effective to have the annual capitation payment also include coverage for these and other relatively routine medical services.
- Capitation rates in Ontario, similar to those in other Canadian provinces, are based only on the patient's age and sex, and do not consider the patient's health condition and health-care needs. As a result, the physician is paid the same for healthy patients (who require few or no medical services during the year) as for patients of the same age and sex who have multiple medical conditions. This situation can encourage physicians to de-enrol patients requiring more medical care, because a physician can receive more funding for providing these patients with medical services under the traditional fee-for-service payment model.

OVERALL MINISTRY RESPONSE

The Ministry of Health and Long-Term Care (Ministry) welcomes the advice contained in this value-for-money audit. The audit acknowledges the progress achieved in increasing the number of Ontarians who have access to a family doctor. As the audit notes, large-scale changes to the traditional payment methods for family physicians were accompanied by a range of incentives and bonuses.

Primary-health-care reform has been a significant government priority since the mid-1990s. In its reform initiatives, the Ministry has worked collaboratively with the Ontario Medical Association (OMA) to develop and promote alternate funding arrangements for family physicians that address patient-access issues. Since 1998, the Ministry, in co-operation with the OMA, has established new alternative funding models, and amended existing models, to promote family-physician participation and desired outcomes within the primary-care sector. As of September 2011, the success of these models has been great: 7,739 Ontario doctors, in 731 groups, are now providing primary health care to 9.6 million enrolled Ontario residents. Many of these groups are also participating in Ontario's Family Health Teams, and are now working with nurses, nurse practitioners, social workers, and others. Early evaluation results indicate that Ontario residents are pleased with these changes. However, as the Ministry moves forward in its primary-care reform initiatives, there is a need to balance the needs of the province's physicians with those of the patients, as well as the need to be accountable to taxpayers.

Certain aspects of the agreements reflect early thinking on how incentives might encourage participation by family physicians as well as enhance and improve preventive and comprehensive primary health care. A thorough formal evaluation of these models will provide an opportunity to adjust the models based on

experience and study. The stability provided by our success in attracting large numbers of physicians to these arrangements will also provide us with an opportunity to implement more complete and effective administrative and contract-monitoring mechanisms.

Detailed Audit Observations

OVERVIEW

The Ministry's goals for alternate funding arrangements for family physicians include:

- improving patient access to care;
- promoting preventive care and chronic disease management;
- providing income stability for physicians; and
- providing expenditure predictability for the government.

To meet these goals, various alternate funding arrangements for family physicians have been negotiated between the Ministry and the Ontario Medical Association. Unlike traditional fee-for-service payments to physicians, these funding arrangements generally require physicians to provide at least some patient care outside of regular business hours, such as evening hours. As well, most of these funding arrangements require physicians to work in groups of three or more, to better ensure that a physician is available when a patient needs access to care.

Physicians can choose whether or not to participate in an alternate funding arrangement, and also have the option of changing to a different alternate funding arrangement or going back to traditional fee-for-service payments. Therefore, to encourage physicians to join and remain in alternate funding arrangements, the Ministry has negotiated arrangements with different payment types. Selected payment types are shown in Figure 1. A few of the arrangements, such as the Family Health

Figure 1: Selected Types of Payments under Alternate Funding Arrangements for Family Physicians

Prepared by the Office of the Auditor General of Ontario

| Type of Payment | Description |
|-----------------------------------|---|
| base capitation | a fixed amount paid for each enrolled patient, based on age and sex, for providing services listed in the contract, regardless of the number of services performed or the number of times the patient visits the physician (for example, base capitation for FHOs ranges from about \$58 to \$521 per patient, and for FHNs from about \$52 to \$367) |
| access bonus | a portion of the base capitation that is reduced when enrolled patients seek care for services listed in the alternate funding arrangement from a physician outside the group the patients are enrolled with |
| comprehensive care capitation | a fixed amount paid for each enrolled patient, based on age and sex, for being responsible for a patient's overall care and co-ordinating medical services, such as referrals to other health-care providers |
| complex capitation | a fixed amount paid for enrolling a "hard-to-care-for" patient |
| enhanced fee-for-service | physicians bill OHIP and are paid at a rate higher than the traditional fee-for-service value for each patient service provided; the amount in excess of the traditional fee-for-service value is referred to as a "top-up" payment |
| fee-for-service | physicians bill OHIP and are paid the established fee per the OHIP fee schedule for each service provided to a patient |
| incentives | additional payments to physicians to provide specific services, such as patient care on weekends, preventive care, and diabetes management; encourage certain activities (e.g., enrolment of certain types of patients, such as hard-to-care-for patients); and compensate physicians for continuing medical education courses |
| shadow billing | physicians who receive base capitation funding can bill OHIP and be paid a percentage of the traditional fee-for-service amount for patient services listed in the alternate funding arrangement; physicians are generally eligible for either shadow billing or enhanced fee-for-service |
| telephone health advisory service | amount paid to physicians to be on call to provide after-hours telephone health advice for their enrolled patients |

Group arrangement, still pay physicians primarily on a fee-for-service basis, but at a rate higher than the traditional fee-for-service value; this approach is called enhanced fee-for-service. However, since such approaches provide neither physician income stability nor cost predictability, most of the funding arrangements, including the Family Health Organization and Family Health Network arrangements, pay physicians primarily through capitation. Under this approach, physicians receive a fixed annual amount (known as base capitation) for each enrolled patient (that is, each patient who signs a form to belong to the family physician's practice), based on the patient's age and sex, regardless of the number of times the patient visits his or her physician. This fixed annual amount pays for certain patient services, which are listed in each alternate funding arrangement contract (often called a "basket" of services). The listed services vary by funding arrange-

ment—for example, Family Health Organization and Family Health Network arrangements have different listed services—so the capitation rates paid under each arrangement differ.

Under the capitation-based arrangements, physicians are also allowed to bill OHIP for a portion, typically 10%, of the traditional fee-for-service value of the listed services whenever they actually provide each service to an enrolled patient. This approach, called shadow billing, provides the Ministry with information about the actual number of patients seen and clinical services provided. As well, physicians can bill the full traditional fee-for-service value for any services provided that are not listed in the contract (that is, not part of the "basket" of services), and for all services provided to non-enrolled patients. In addition, all alternate funding arrangements offer extra incentive payments and bonuses designed to encourage certain

physician activities, such as providing diabetes management and preventive care, including screening for breast and colon cancer.

Family physicians who choose to participate in an alternate funding arrangement sign a contract with the Ministry, the Ontario Medical Association, and the other physicians, if any, participating in the arrangement. Under these agreements, physicians working in groups may either be signatory physicians (who are paid by the Ministry for meeting the agreement's obligations) or contract physicians (who are paid either primarily by the Ministry or by the signatory physicians, depending on the alternate funding arrangement). Physicians are permitted to be a signatory in only one agreement and a contract physician in no more than three other agreements. As of March 31, 2011, about 40% of the groups used contract physicians, and about 25% of the contract physicians worked for more than one physician group.

Most family physicians participating in an alternate funding arrangement have chosen a Family Health Organization, Family Health Group or Family Health Network arrangement. These arrangements provide services to more than 90% of the enrolled patients, as shown in Figure 2. Physicians participating in these arrangements are compensated as shown in Figure 3.

The Ministry introduced Family Health Teams in 2005 to bring together various interdisciplinary health-care providers, such as nurses, social workers, and psychologists, to work with physicians to, among other things, co-ordinate and enhance the

quality of care for patients. While alternate funding arrangements pay for physician services, Family Health Team funding pays for other costs, such as the services of the interdisciplinary health-care providers, as well as related administrative and other overhead costs. As well, one-time funding is provided to Family Health Teams for office renovations and information technology. Physicians in certain alternate funding arrangements—including Family Health Organizations and Family Health Networks, but not Family Health Groups—may apply to the Ministry to establish a Family Health Team. However, since traditionally physicians paid through fee-for-service are required to pay for most of their own overhead costs, including nursing and other staff costs, many more physician practices apply to the Ministry for funding than are approved. (For example, the Ministry received more than 70 applications after its most recent announcement that 30 new Family Health Teams would be approved.) As of March 2011, more than 2,200 physicians from almost 240 physician groups were participating in 156 Family Health Teams, which received \$244 million in Ministry funding in the 2010/11 fiscal year. The Ministry expected that an additional 21 teams it had approved would be operational by fall 2011.

Alternate funding arrangements for family physicians are managed by the Ministry's Primary Health Care Branch. Other Ministry branches involved in administering the contracts include the Financial Management Branch, which is responsible for processing physician payments and conducting financial forecasting and reporting; the Health

Figure 2: Physicians and Patients in Alternate Funding Arrangements, as of March 31, 2011

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

| Alternate Funding Arrangement | # of Physician Groups/Practices | # of Physicians | # of Enrolled Patients | % of Enrolled Patients |
|--------------------------------------|---------------------------------|-----------------|------------------------|------------------------|
| Family Health Organization (FHO) | 352 | 3,549 | 4,877,000 | 51 |
| Family Health Group (FHG) | 238 | 3,056 | 3,712,000 | 39 |
| Family Health Network (FHN) | 36 | 350 | 356,000 | 4 |
| other alternate funding arrangements | 73 | 745 | 584,000 | 6 |
| Total | 699 | 7,700 | 9,529,000 | 100 |

Data Branch, which is responsible for collecting statistics, analyzing trends, and calculating certain payments; the Registration and Claims Branch, which is responsible for, among other things, processing medical claims, patient enrolments,

and new 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.

Figure 3: Payment Methods for Selected Alternate Funding Arrangements for Family Physicians

Prepared by the Office of the Auditor General of Ontario

| Type of Alternate Funding Arrangement | Start Date | How Physicians Are Paid |
|---------------------------------------|------------|--|
| Family Health Organization (FHO) | 2006 | <p><i>Base and comprehensive care capitation, shadow billing, and incentives for enrolled patients</i></p> <p>Base capitation payment covers 118 listed services. Shadow billing is paid at 10% of the traditional fee-for-service value.</p> <p>Physicians also receive additional payments, including:</p> <ul style="list-style-type: none"> • fee-for-service payments for any service not listed in the contract and for all services provided to non-enrolled patients • incentive payments for services such as preventive care, diabetes management, after-hours services, and enrolling unattached patients • complex capitation payments for “hard-to-care-for” patients • payments for being on call to provide after-hours telephone health advice to enrolled patients • \$5,000 to \$11,000 per year if they work in rural communities <p>Funding of \$12,500 to \$25,000 per year is provided to practices with at least five physicians to hire an office administrator.</p> |
| Family Health Group (FHG) | 2003 | <p><i>Enhanced fee-for-service and incentives for ministry-assigned patients and enrolled patients, as well as comprehensive care capitation payments for enrolled patients</i></p> <p>Enhanced fee-for-service is 110% of the traditional fee-for-service amount.</p> <p>Physicians also receive additional payments, including:</p> <ul style="list-style-type: none"> • complex capitation payments for “hard-to-care-for” patients • incentive payments for services such as preventive care, diabetes management, after-hours services, and enrolling unattached patients • payments for being on call to provide after-hours telephone health advice to enrolled patients |
| Family Health Network (FHN) | 2001 | <p><i>Base and comprehensive care capitation, shadow billing, and incentives for enrolled patients</i></p> <p>Base capitation payment covers 56 listed services. The base capitation rate is lower than for Family Health Organizations, because fewer services are listed. Shadow billing is paid at 10% of the traditional fee-for-service value.</p> <p>As with Family Health Organizations, physicians also receive additional payments, including:</p> <ul style="list-style-type: none"> • fee-for-service payments for any service not listed in the contract and for all services provided to non-enrolled patients • incentive payments for services such as preventive care, diabetes management, after-hours services, and enrolling unattached patients • complex capitation payments for “hard-to-care-for” patients • payments for being on call to provide after-hours telephone health advice to enrolled patients • \$5,000 to \$11,000 per year if they work in rural communities <p>Funding of \$12,500 to \$25,000 per year is provided to practices with at least five physicians to hire an office administrator.</p> |

INITIATIVES TO IMPROVE ALTERNATE FUNDING ARRANGEMENTS

Ministry initiatives to improve alternate funding arrangements for family physicians include negotiated changes to the Physician Services Agreement, as well as the following:

- Since 2006, the Ministry has had a telephone survey conducted to obtain patients' perspectives on, among other things, access to care provided by family physicians. About 2,100 Ontarians are surveyed every three months as part of this Primary Care Access Survey. The Ministry uses this information to develop strategies that will improve patients' access to care, such as helping patients find a family physician.
- In 2007, the Ministry created the Quality Management Collaborative (now part of Health Quality Ontario) to help Family Health Teams implement a team-based model of delivering primary health care. The organization's current objectives include using performance measurement to plan, test, and evaluate improvements in the organization and delivery of primary health care.
- In December 2008, the Ministry commissioned the Conference Board of Canada to conduct a five-year study on Family Health Teams to identify their successes and shortcomings. Each year, the Ministry has been receiving interim study results, which focus on areas such as team functioning, patient access, and chronic disease management. The Ministry indicated that it will use the final report—expected in 2013—to assist it in determining whether any changes should be made regarding Family Health Teams.
- In February 2009, the Ministry launched Health Care Connect to help patients who have no family physician find one. By March 31, 2011, more than 100,000 patients had registered with the program, and 60% of those registered had been matched with a

physician. The Ministry offers a bonus payment to family physicians participating in alternate funding arrangements who accept patients who have been identified by the program as complex-vulnerable (that is, harder to care for). Almost 8,000 patients had been identified as complex-vulnerable, and almost 6,000 of these had been matched with a physician. This initiative is ongoing.

ESTABLISHING ALTERNATE FUNDING ARRANGEMENTS

Alternate funding arrangements for family physicians are agreements negotiated between the Ministry and the Ontario Medical Association, which bargains on behalf of physicians in Ontario. Since 2000, negotiations have taken place every four years, with any new funding arrangements or changes to existing arrangements requiring the agreement of both the Ministry and the Ontario Medical Association. Standard contracts were initially developed for each alternate funding arrangement, but negotiated changes are generally in other documents, such as the 2004 and 2008 Physician Services Agreement. For example, the Physician Services Agreement contains information on new or additional fees (such as an increase to after-hours premiums and new fees for smoking cessation programs), as well as incentives and bonuses (such as bonuses for having patients participate in colorectal screening).

We inquired whether the Ministry conducted an in-depth analysis of the anticipated costs of the new alternate funding arrangements before it entered into negotiations with the Ontario Medical Association, so that the total costs and expected benefits could be compared with those of the traditional fee-for-service model. Such an analysis would also be useful in ensuring that the Ministry had a well-informed bargaining position. Although the Ministry indicated that such an analysis had been performed, it was unable to locate this analysis. However, the Ministry did have information on the

expected costs of changes (such as new incentives) to alternate funding arrangements.

Notwithstanding this, once the alternate funding arrangements had been negotiated, we would have expected the Ministry to periodically analyze these arrangements to determine which features best met the Ministry's goals, including patient access to care, and how the relative cost of the new arrangements compared with the traditional fee-for-service model. This information would also be useful in future negotiations with the Ontario Medical Association. We were informed that the Ministry last performed a cost comparison of the alternate funding arrangements in the 2007/08 fiscal year. At that time, the average gross income of family physicians paid solely on a fee-for-service basis was estimated to be about \$285,000, whereas physicians participating in a Family Health Organization (FHO) made about \$405,000, those in a Family Health Network (FHN) made about \$360,000, and those in a Family Health Group (FHG) made about \$375,000. From these amounts, physicians must pay the costs to run their practice, including any overhead costs—as well as, for FHOs and FHNs, amounts payable to participating contract physicians, if any.

The Ontario Medical Association informs family physicians about alternate funding arrangements that they may join. Family physicians or groups of physicians interested in joining an arrangement then contact the Ministry. The Ministry verifies the credentials of applying physicians and ensures that each physician is a signatory physician under only one agreement and is a contract physician under no more than three agreements.

Contracts, which set out the compensation arrangements as well as the services that are required to be provided, are signed by the signatory physicians who initially form the group and by representatives of the Ministry and the Ontario Medical Association. As well, all signatory and contract physicians participating in the group are required to sign a physician declaration form that, among other things, binds them to the terms of the

contract. In the sample of contracts we tested for physicians participating in an alternate funding arrangement between April and December 2010, we found that 13% of physicians in FHGs and 18% of physicians in FHOs had not signed either the contract or the declaration form. There is a risk that physicians who have not signed the contract and/or the declaration form may not fully understand their obligations and, for example, might not provide the level of patient services required under the alternate funding arrangement.

RECOMMENDATION 1

To help ensure that alternate funding arrangements for family physicians meet the goals and objectives of the Ministry of Health and Long-Term Care (Ministry) in a cost-effective manner, the Ministry should:

- periodically analyze the costs and benefits of existing alternate funding arrangements to determine whether the incremental costs of these arrangements are justified compared to the traditional fee-for-service model;
- when negotiating alternate funding arrangements with the Ontario Medical Association, ensure that it has good information on the relative costs and benefits of new arrangements being considered as compared to the traditional fee-for-service compensation model, so that it is able to take a well-informed bargaining position; and
- require all physicians to sign a 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.

The Ministry agrees with the need to evaluate the costs and benefits of existing alternate

funding arrangements to ensure that the goals established under primary-health-care reform, particularly improved access to comprehensive primary-care services, are being achieved. The Ministry will commission a formal external evaluation of the two main alternate funding arrangements: Family Health Groups and Family Health Organizations. The results of the evaluation will inform amendments to the alternate funding arrangements to maximize benefits of the models and improve patient access to quality comprehensive primary-care services in Ontario.

The Ministry will continue the practice that any new alternate funding arrangements, as well as any amendments to existing alternate funding arrangements, are fully costed prior to negotiations, and as negotiations proceed, with the Ontario Medical Association (OMA), to ensure that the Ministry is negotiating from a strong knowledge base. As was the practice in the negotiation of the 2008 Physician Services Agreement (PSA), the 2012 negotiations with the OMA will be based on an approved mandate with costed proposals and data to support proposed changes to physician payments. Further, as with the 2008 PSA, expenditures for new initiatives under future agreements will be tracked and compared to projected costs to identify issues for review by the Physician Services Committee.

The Ministry will implement procedures to ensure that payments under alternate funding arrangements do not commence until signed contracts are in place.

ENROLLED PATIENTS

By enrolling with a physician who is participating in an alternate funding arrangement, patients agree to seek treatment mainly from this physician or another physician working in the same family

practice, except in an emergency. Patients are not required to enrol, and family physicians are not supposed to refuse medical care to any of their patients who prefer not to enrol in the new arrangement.

In order to enrol with a family physician who is participating in an alternate funding arrangement, a patient must sign an enrolment form. Physicians forward the forms to the Ministry. The Ministry verifies that the patient has a valid Ontario health card and is therefore eligible for Ontario health insurance: if so, the Ministry records the patient's enrolment in its Client Agency Program Enrolment (CAPE) database, which lists all patients who have ever enrolled or de-enrolled with a family physician. If the patient was already enrolled with another physician, CAPE automatically changes the patient's enrolment to the new physician. Based on our analysis of the CAPE database, the Ministry's controls were adequate to ensure that no patient was enrolled with more than one physician as of April 2011.

At the time of our audit, the Ministry was processing more than 100,000 enrolment requests and 10,000 de-enrolment requests every month. We also noted that the Ministry was up to date on entering and removing patients from the CAPE database. However, procedures need to be enhanced to help identify enrolled patients who may no longer be seeing the physician they are enrolled with, even though this physician is still being paid for being their family physician. For example:

- There is no tracking of enrolled patients who rarely if ever visit the family physician they are enrolled with. We identified 1.9 million patients enrolled with either an FHO or FHG physician who had not visited their physician's practice at all in the 2009/10 fiscal year. Almost half visited another physician, who received a fee-for-service payment for the medical services provided. The physicians with whom the patients were enrolled received a total of \$123 million (after deducting the fees paid to the other physicians

visited) just for having these patients enrolled. The Ministry indicated that because capitation payments are based on the average level of physician services used by persons of the same age and sex, it expected payments for patients who seldom or never visited their physician to be offset by patients who require a high level of care.

- Although the Ministry identifies the total number of times in the month that a physician's enrolled patients seek services from outside their physician's practice, the Ministry does not track this information by patient. Of the patients who had made at least one visit to the FHO or FHG they were enrolled with, our analysis identified 400,000 patients who saw a family physician outside of their physician's practice more often than they saw a family physician in the practice with which they were enrolled during the 2009/10 fiscal year.
- Alternate funding arrangements require that enrolled patients reside within 100 kilometres of the physician's practice. However, the Ministry has no procedures for identifying and de-enrolling patients who move outside their physician's practice area. For example, patient address changes in the Ministry's registered persons database, which lists all persons eligible for Ontario health insurance, do not trigger a check of enrolled patients. Even if they did, the registered persons database is not always updated on a timely basis. For example, if a patient moves outside the country, the Ministry will be notified only if the patient fails to renew his or her photo health card (which could be up to five years after the move). Moreover, since 2.7 million enrolled patients still use the red-and-white health cards, which have no expiry date, it may be even more difficult to detect when they move. The Ministry indicated that patients are legally responsible for telling the Ministry if they no longer qualify for OHIP benefits—for example, when they move to another country.

Patients who move are unlikely to see the physician they are enrolled with, and if they see a physician closer to their new home who does not enrol the patient as part of an alternate payment plan, their former physician will still be paid the annual capitation fee, and the new physician will be remunerated through the traditional fee-for-service model, unless the Ministry is made aware that the patient has changed physicians. The Ministry indicated that physicians are contractually responsible for notifying the Ministry if a patient moves; however, we believe that physicians often would not know when a patient moves, especially given the number of patients who seldom or never see the physician they are enrolled with. The Ministry further indicated that physicians would de-enrol a patient if that patient saw another family physician, but given that almost half the patients who never saw the physician they are enrolled with did visit another physician, we questioned this assumption.

In April 2011, enrolled patients represented about 70% of the population in Ontario. However, we noted that many people didn't know that they were enrolled. In fact, the Primary Care Access Surveys conducted on the Ministry's behalf for the year ended September 30, 2010, indicated that only 32% of respondents believed they were enrolled with a family physician. Based on these results, we questioned whether patients understand what it means when their family physicians ask them to complete an enrolment form. There is also a risk that enrolment forms could be submitted by physicians for patients who have not agreed to enrol.

According to the enrolment form, either the patient or the physician can end the enrolment relationship. The patient can end his or her enrolment by notifying either the physician or the Ministry (through Service Ontario). Most de-enrolments are initiated by a physician, who must complete a form requesting that the Ministry de-enrol the patient. This form indicates only broad reasons

for the de-enrolment, such as “physician ended the patient enrolment.” De-enrolment requests from physicians may occur because de-enrolling the patient would be more lucrative for the physician—that is, the physician would be paid more money for the patient through traditional fee-for-service payments (which might be the case, for instance, if the patient visits the physician frequently).

Enrolment Size

The Family Health Network (FHN) and Family Health Organization (FHO) arrangements require each physician group to enrol a minimum number of patients. For groups with three to five physicians, the minimum enrolment size is 800 patients per physician. Individual physicians in a group are allowed to enrol fewer patients if other physicians in the same group enrol more (for example, for a three-physician practice to meet its minimum of 2,400 patients, two physicians might enrol 100 patients each and the third physician might enrol 2,200 patients). For all groups with more than five physicians, the minimum is 4,000 patients. For instance, in a 10-physician group, each physician would be required to enrol only 400 patients—a situation that could decrease access for people in the area who have no family physician. Family Health Groups (FHGs) have no minimum enrolment requirements.

Our analysis of the enrolment data indicated that:

- 93% of FHOs and FHNs with five or fewer physicians that had been in operation longer than one year had met the minimum requirement by enrolling 800 patients per physician; and
- the median number of enrolled patients per physician varied from about 1,025 to 1,400 depending on the arrangement type, as shown in Figure 4.

The actual number of patients these physicians see may be higher, because all participating phys-

icians can also provide primary-care services to patients who are not enrolled.

As is the case in many other jurisdictions, there is no limit on the number of patients an individual physician can enrol, and there are no guidelines on the optimal number of patients a family physician can reasonably expect to care for, whether the patients are enrolled with the physician or not. Although there is no maximum number, the FHO and FHN contracts state that if a physician group’s average number of enrolled patients exceeds 2,400 per physician, capitation payments are reduced by half for those patients above 2,400. Our analysis indicated that as of December 31, 2010, there were 12 physician groups, with a total of 38 doctors, that had enrolled more than 2,400 patients per physician.

Hard-to-care-for Patients

Some patients require more frequent visits to their family physician because of ongoing health issues. These patients are generally considered hard to care for, although the Ministry does not have a specific definition to identify such patients.

Under the alternate funding arrangements, although capitation rates generally get higher as patients get older, the rates are not adjusted based on a patient’s health needs. In 2009, a report by the Institute for Clinical Evaluative Sciences found that in comparison to physicians paid through enhanced fee-for-service arrangements, such as FHGs, physicians participating in Family Health Teams enrolled fewer sick patients and fewer patients who

Figure 4: Median Number of Enrolled Patients per Physician, as of December 31, 2010

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

| Type of Alternate Funding Arrangement | Median # of Enrolled Patients per Physician |
|---------------------------------------|---|
| Family Health Group (FHG) | 1,200 |
| Family Health Network (FHN) | 1,025 |
| Family Health Organization (FHO) | 1,400 |

made frequent visits to their physician. The reason for this difference was not clear.

To encourage physicians to enrol hard-to-care-for patients, the Ministry offers short-term incentives. In order for physicians to earn these incentives, a person who does not have a family physician must first call the Ministry's Health Care Connect service, which helps people find a family physician. Health Care Connect evaluates the level of medical services the person requires to determine if he or she is a "complex-vulnerable" person (that is, hard to care for). If the person is so designated, the physician who enrolls this patient will receive a one-time signing bonus of \$350. In addition, during the first 12 months of enrolment, an FHO or FHN physician will receive an extra \$500 in total capitation payments for the patient, and an FHG physician will receive 150% of the value of any fee-for-service claim submitted for the patient.

After the first year, no additional bonuses or incentives are available to physicians caring for such patients. In the 2009/10 fiscal year, Health Care Connect co-ordinated the enrolment of 1,600 complex-vulnerable persons. At the time of our audit fieldwork, the Ministry had not monitored whether any of these patients are de-enrolled by their physicians once the short-term financial incentives end. However, the Ministry indicated that Health Care Connect had not notified the Ministry of any problems with previously matched complex-vulnerable patients seeking its assistance again after one year.

RECOMMENDATION 2

To better ensure that alternate funding arrangements are cost-effective and that patients have access to family physicians when needed, the Ministry of Health and Long-Term Care should:

- periodically review the number of patients who do not see the physician they are enrolled with, and assess whether continuing to pay physicians the full annual capitation fee for these patients is reasonable;

- review the impact of its policy that allows practices with more than five physicians to enrol only 4,000 patients in total, rather than the 800 patients per physician required by practices with fewer physicians, to determine the impact this policy has on access for people with no family physician; and
- review the number of patients being de-enrolled by their physician to determine whether a significant number of these patients are in the hard-to-care-for category, and, if so, whether the current financial incentive arrangements should be revised.

MINISTRY RESPONSE

The Ministry is supportive of conducting one or more policy reviews to evaluate whether the current enrolment-related provisions in the alternate funding arrangements contribute toward improved access to primary-care services for enrolled patients. The Ministry notes that significant research on the delivery of primary-care services is available to it, which can inform and support its policy reviews and corresponding contract amendments where necessary.

The Ministry's policy reviews will address the issues identified in the audit report:

- the appropriateness of paying capitation payments in respect of enrolled patients who do not access care from the physician they are enrolled with during a one-year period;
- the impact on access to care resulting from controls on minimum enrolment size; and
- the linkage between de-enrolment and patient complexity and whether payment incentives are required to ensure continued access to care.

Work that is currently in progress by a joint Ministry and Ontario Medical Association working group, with support from the Institute for Clinical Evaluative Sciences, may resolve issues related to maintaining complex patients in capitation-based funding models. This group

is evaluating options for modifying the current age/sex capitation rate to include an acuity/complexity modifier, and is expected to submit its final report in December 2011.

PATIENT ACCESS TO PRIMARY-CARE SERVICES

Hours of Services

Contracts signed by physicians participating in alternate funding arrangements generally state that the physician group “shall ensure a sufficient number of physicians are available to provide the services during reasonable and regular office hours from Monday through Friday, sufficient and convenient to serve enrolled patients.” The contracts do not further specify what constitutes “a sufficient number of physicians,” “reasonable and regular office hours,” or “sufficient and convenient to serve enrolled patients.” According to the Ministry, these terms were intentionally not further defined for various reasons, including giving physicians flexibility in operating their practices and avoiding contract restrictions that would prevent physicians from joining alternate funding arrangements.

Further, physician practices are required to provide at least one three-hour block of after-hours services per week for each physician in the group, to a maximum of five three-hour blocks per week for practices with five or more physicians. The contracts define “after-hours” as Monday to Thursday after 5 p.m. or any time on the weekend—that is, any time from Friday through Sunday. (Physicians are required to have some regular office hours on Fridays, but can also provide after-hours services any time outside of their regular hours that day.) Although the after-hours blocks must occur on different days, unlike regular office hours, there is no requirement in the contract for after-hours services to be “sufficient” or “convenient.” For example:

- Where a practice has more than five physicians, the minimum number of after-hours

services required per week is five three-hour blocks. Eighty-seven percent of Family Health Networks (FHNs), 64% of Family Health Organizations (FHOs), and 53% of Family Health Groups (FHGs) have more than five physicians in a group. Such FHNs, FHOs, and FHGs average from 10,000 to 24,000 patients. However, only one physician is required to be available during each after-hours block, and therefore we believe it would be worthwhile for the Ministry to assess whether these practices are providing sufficient evening and weekend availability to meet their patients’ needs.

- Even though some groups operate out of multiple locations, the after-hours services need only be offered at one location, which may not be convenient for many of the enrolled patients.

At the time they are established, physician groups participating in an FHN, FHO, or FHG provide their hours of operation to the Ministry. Only FHGs are contractually required to update the Ministry if their office hours change. Although the Ministry was not periodically monitoring changes to FHN, FHO, or FHG office hours at the time of our audit fieldwork, the Ministry indicated that this information could be obtained from the provider of its Telephone Health Advisory Service. The Ministry initiated a project in summer 2011 to collect information on the regular and after-hours schedules of FHNs, FHOs, and FHGs.

We reviewed ministry information for the 2009/10 fiscal year on which day of the week physician services were provided and on whether the physicians participating in alternate funding arrangements billed the services as having taken place during regular hours or after hours (for the latter, they receive a premium payment from the Ministry). For FHGs, FHOs, and FHNs, our analysis showed that less than 15% of patient services were provided on Fridays, and only about 6% of services were provided on Saturdays and Sundays. We also found that 92% of services were provided during regular office hours.

At the time of our audit, more than 100 FHG, FHN, and FHO groups were exempt from providing after-hours services. Exemptions can be obtained if more than 50% of physicians in the group provide certain other services outside regular hours (for example, hospital emergency-room coverage or obstetrical services) and the group obtains ministry approval. Physicians are not required to state how many hours of these services they provide or otherwise supply any proof that they are providing these services. Until 2011, exemption approvals had no expiry date. Starting in 2011, physician groups will be required to apply for the after-hours exemption annually, and every time a physician joins or leaves the group. The Ministry indicated that it reviewed physician groups' eligibility for exemptions a few years ago, and found that all exempted groups were eligible. However, no documentation of that review was maintained, or on how eligibility was confirmed.

In February 2011, the Ministry conducted an ad-hoc review of "after-hours" claims submitted by FHNs, FHOs, and FHGs for June 2010 to determine whether physician groups complied with the after-hours service requirements. Ministry results indicated that only 41% of FHNs, 60% of FHOs, and 74% of FHGs were providing after-hours services in accordance with their contracts. Physician groups providing less than 40% of the required after-hours services were sent a letter requesting an explanation. Some groups said that they met the exemption criteria but had not known they required ministry approval, and other groups said that they provided the services but didn't bill the after-hours code, despite the premium payment they would receive for providing after-hours services. The Ministry informed us that it is now requesting explanations from the rest of the physician groups with less than 100% compliance.

Physicians' Service Levels

The Ministry obtained some information on the wait time to see a family physician through its Primary Care Access Survey. Approximately 2,100

Ontarians aged 16 and older were surveyed every three months. The most recent survey responses available for our review were for the year ending September 30, 2010. Where appropriate, we compared these survey responses with responses from previous years. Based on survey responses, the Ministry projected that the number of Ontarians with a family physician increased by almost 500,000 from 2007 to 2010.

Overall, for persons with a family physician, responses to questions regarding access were similar, regardless of whether the person was enrolled with a physician in an alternate funding arrangement or the person's physician was paid under the traditional fee-for-service model. As well, the length of time patients currently waited to see a physician generally had not changed significantly from responses received approximately three years earlier, even though many more patients were now enrolled with a physician participating in an alternate funding arrangement practice. For instance:

- For persons who needed to see a physician because they were sick, 27% of respondents with a family physician (whether enrolled with the physician or not) said they saw a physician the same day; an additional 17% saw a physician the next day, and 44% were able to see a physician within two to seven days. The rest waited longer.
- For persons who needed to see a physician for monitoring an ongoing health problem, 12% of respondents with a family physician (whether enrolled or not) said they saw a physician the same day, 10% saw a physician the next day, and 45% were able to see a physician within two to seven days. The rest waited longer.
- Among respondents with a family physician (whether enrolled or not) who visited their physician, 93% were satisfied with the care they received. Respondents without a family physician were about 10% less likely to be satisfied with the care they received.

- Among respondents with a family physician (whether enrolled or not) who went to an emergency department, 15% went because their family physician was not available. The survey did not distinguish between regular office hours, weeknights, or weekends.
- Among respondents with a family physician (whether enrolled or not) who went to a walk-in clinic, 47% went because their family physician was not available. Another 36% said they went to a walk-in clinic because it was easier or more convenient. Compared to the 2008/09 fiscal year, there was a 10% increase in the number of respondents who used a walk-in clinic because their family physician was not available.

We also noted that interim results of the Ministry-commissioned study on Family Health Teams have indicated that enrolled patients were generally satisfied with their access to health services.

RECOMMENDATION 3

To ensure that alternate funding arrangements are meeting their goal of improving access to family physicians, the Ministry of Health and Long-Term Care (Ministry) should:

- periodically monitor whether physicians participating in alternate funding arrangements provide patients with sufficient and convenient hours of availability, including after-hours availability, as required by the arrangements; and
- conduct a formal review of whether alternate funding arrangements are meeting the goal of improving access, especially given that the Ministry's Primary Care Access Survey indicates little change in the last three years in the wait times for seeing a family physician.

MINISTRY RESPONSE

The Ministry supports the monitoring of alternate funding arrangements to ensure that patients have access to sufficient and convenient

hours of availability, including after-hours availability. The Ministry will develop service standards and performance measures that can be used to ensure that physician practices are open and available to their enrolled patients.

Performance measures will be incorporated into the alternate funding arrangements to ensure that physicians participating in the arrangements are aware of expectations and mechanisms that will be used by the Ministry to monitor compliance.

PAYING FAMILY PHYSICIANS

Non-fee-for-service payments made under alternate funding arrangements for family physicians increased significantly between the 2006/07 and 2009/10 fiscal years, with payments under the Family Health Organization arrangement (including \$153 million relating to Family Health Team funding) accounting for most of the increase, as shown in Figure 5. During the same time period, the total number of physicians participating in alternate funding arrangements increased by about 730 (11%) and the number of enrolled patients increased by almost 1.8 million (24%). Total funding to all family physicians increased by 32%, from \$2.8 billion to \$3.7 billion, between the 2006/07 and 2009/10 fiscal years. In the 2009/10 fiscal year, 66% of the total number of family physicians in Ontario participated in an alternate funding arrangement. They received 76% of the total amount paid to all family physicians.

At our request, the Ministry determined that family physicians participating in an alternate funding arrangement also earned \$1.2 billion in additional fee-for-service payments in the 2009/10 fiscal year for providing medical services not included in the list of services covered by the annual base capitation payment, as well as for providing services to non-enrolled patients. The Ministry does not know how much each physician who is participating in

Figure 5: Expenditures by Alternate Funding Arrangement, 2006/07–2009/10 (\$ million)

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

| Funding Model | 2006/07 | 2007/08 | 2008/09 | 2009/10 |
|--|------------|------------|--------------|--------------|
| Family Health Organizations (FHO) ¹ | 59 | 271 | 651 | 977 |
| Family Health Groups (FHG) ² | 229 | 269 | 278 | 277 |
| Family Health Networks (FHN) ¹ | 209 | 276 | 201 | 156 |
| other | 256 | 152 | 181 | 221 |
| Total | 753 | 968 | 1,311 | 1,631 |

1. Excludes fee-for-service payments made to physicians for providing services to non-enrolled patients and for providing non-listed services to enrolled patients

2. Excludes traditional fee-for-service payments before the 10% top-up

an alternate funding arrangement receives in total, because the alternate funding arrangements allow some or all payments to be made directly to the physician group for distribution at its discretion.

Ministry staff informed us that the Family Health Group (FHG) arrangement was initially designed to pay more than the traditional fee-for-service amount in order to encourage physicians to join an alternate funding arrangement. It pays physicians 110% of the traditional fee-for-service amount. For other alternate funding arrangements, such as Family Health Organizations (FHOs) and Family Health Networks (FHNs), base capitation payments, as well as the continued fee-for-service payments for non-listed services and for services provided to non-enrolled patients, were designed to be expenditure-neutral—that is, costing neither more or less than before. The Ministry indicated that additional payments, such as bonuses and incentives, are included in all alternate funding arrangements to compensate and reward physicians for providing high-quality comprehensive care. This in turn makes these arrangements more lucrative for physicians than being paid through the traditional fee-for-service model.

Payments to family physicians under the alternate funding arrangements are complicated. For example, in the 2009/10 fiscal year, there were up to 42 types of payments made to physicians working in FHGs, and 61 types of payments made to physicians working in FHOs. (Selected payment types are shown in Figure 1.) Most of these payments are incentives in the form of premiums and

bonuses. For example, under both FHG and FHO arrangements, there are eight types of incentives offered to physicians for enrolling patients, and 12 types of incentives to physicians for providing preventive-care activities, such as vaccinations and cancer-screening tests.

Further, the basis for determining the amount of payment differs among the various payment types. For example, some payments (such as capitation) are based on the number (and certain other characteristics) of enrolled patients. Other payments (such as shadow billing and after-hours incentives) are based on the number of actual services provided to enrolled patients. Still other payments (such as administration fees, continuing medical education fees, and fees for being on call for the Telephone Health Advisory Service) are on a per-physician basis. Physicians can also receive bonuses for services their patients receive from other health-care professionals (for example, flu vaccines, mammograms, and colorectal screening) as long as a certain percentage of the physicians' patients receive the services.

The many different payment types make alternate funding arrangements more difficult for the Ministry to administer and monitor. We reviewed the capitation and access bonus payments, which together constitute more than 50% of payments made through the alternate funding arrangements.

Capitation Payments

Physicians participating in FHNs and FHOs generally receive two types of capitation payments (base capitation and comprehensive care capitation) for every enrolled patient, whether or not the patient visits them in a given year. As FHNs and FHOs receive both of these payments for all enrolled patients, we questioned whether the capitation rates could be combined.

We noted that the capitation rates in Ontario, similar to those in other Canadian provinces, are based only on the patient's age and sex, and do not consider the patient's health condition and health-care needs. In comparison, England's capitation payments to physicians consider, in addition to the patient's age and sex, the patient's health condition (morbidity), and New Zealand's consider how frequently the patient uses health-care services. Linking a patient's health condition and need for health-care services to the capitation funding for that patient could encourage physicians to treat hard-to-care-for patients and possibly eliminate the need to offer physicians additional premiums for seeing such patients. The Physician Services Agreement between the Ministry and the Ontario Medical Association indicated that a working group would be established to report to the Ministry by December 2011 on updating the capitation methodology.

The base capitation rate covers patient services listed in the alternate funding arrangement contracts. The capitation payment for each type of alternate funding arrangement includes a different list of patient services. For example, the FHO arrangement covers almost 120 services and has a capitation rate that can be up to 40% higher than the FHN arrangement, which covers only half that many services. The FHO arrangement includes services such as house-call assessments, palliative care, and single-injection chemotherapy, which are not covered by the FHN contract. Physicians under both arrangements still bill the Ministry on a fee-for-service basis for "non-listed" services provided to their enrolled patients. Our analysis indicated

that, despite FHOs having twice as many services listed in their arrangement as FHNs, in the 2009/10 fiscal year, 27% of physician services provided to patients enrolled with an FHO, as compared to 32% of services provided to patients enrolled with an FHN, were non-listed and billed to the Ministry as fee-for-service claims. The Ministry paid FHO and FHN physicians an additional \$72 million and \$13 million, respectively, for the non-listed services.

We further noted that almost 30% of the fee-for-service claims for non-listed services were for flu shots and Pap-smear technical services (that is, the cost of supplies used to perform the test). However, the Ministry had not analyzed which services would be most cost-effective to list in the alternate funding arrangements, or whether it would be beneficial to have capitation payments include most if not all of the more routine or most common medical services.

Access Bonus

Family physicians participating in an FHO or FHN whose enrolled patients seek primary-care services elsewhere lose a portion of their practice's total base capitation, known as the access bonus. This amount is calculated monthly. The loss is equal to the fee-for-service payments made by the Ministry to the physician who treated the patient, to a maximum penalty of 18.59% of the practice's total base capitation for FHOs and 20.65% for FHNs.

In the 2009/10 fiscal year, about 1.3 million patients who were enrolled with an FHO or FHN made 3.7 million visits to family physicians outside their practice. (This represented almost 30% of patients enrolled under these arrangements, and almost 20% of the times patients sought care from a family physician.) As a result, capitation payments for FHO and FHN physicians were reduced by \$54 million and \$4 million, respectively. Ministry data for the 2010 calendar year indicated that 140 FHOs and six FHNs were penalized the maximum amount in at least one month, with 25 FHOs penalized the maximum every month. Because these practices had reached the maximum percentage

penalty, the Ministry could not recover the additional \$11 million that it paid for their enrolled patients who sought care elsewhere. Therefore, the Ministry paid twice for these services—once through capitation payments to FHOs and FHNs and again through fee-for-service payments to other physicians.

We also noted that there is no deduction from the access bonus if an enrolled patient visits an emergency department for non-emergency care. Based on our analysis of claim submissions for the 2009/10 fiscal year, we found that although non-enrolled patients visited emergency departments about 10% of the time for their medical care, enrolled patients visited them slightly less often (about 7% of the time), with more than 40% of enrolled patients' visits being for non-urgent care.

RECOMMENDATION 4

To facilitate the administration of the current complex alternate funding arrangements for family physicians, the Ministry of Health and Long-Term Care (Ministry) should consider reducing the number of arrangements and simplifying the types of payments. Further, to better ensure that the alternate funding arrangements are cost-effective, the Ministry should:

- review the fee-for-service payments to physicians for services not covered by the annual capitation payment, and determine whether significant savings may be possible by having them covered by the capitation payment; and
- consider negotiating a reduction in capitation payments for patients who never or seldom see the physician they are enrolled with, as well as a further reduction in capitation payments to better reflect the cost of non-emergency services that patients obtain from physicians who are not part of the practice they are enrolled with.

MINISTRY RESPONSE

The Ministry agrees that the current array of alternate funding arrangements and the com-

plexity of the payment elements under each of these arrangements are complex. The Ministry supports the concept of simplified agreements and the reduction of the number of alternate funding arrangements.

However, the Ministry recognizes the advantage of using specific bonus and premium payments to encourage the delivery of specific services and/or activities that are a priority for the Ministry. The continuation of bonuses and premiums allows funding to be targeted toward specific programs of interest.

The Ministry will undertake a review of the payment elements under the existing alternate funding arrangements to identify opportunities for simplification.

The Ministry supports a review of existing included and excluded services under the Family Health Network and Family Health Organization alternate funding arrangements, to determine whether changes are required to better reflect the full range of comprehensive primary-care services.

The Ministry is currently in discussion with the Ontario Medical Association (OMA) to consider changes to the capitation payment to reflect patient acuity/complexity. The Ministry will approach the OMA to express its interest in having utilization-based modifiers considered in addition to modifiers based on patient acuity/complexity.

The Ministry and the OMA, through the Primary Health Care Committee, are currently conducting a policy review of the access bonus payment. This policy review will consider current services contributing to the access bonus, contract provisions related to the negative access bonus, and provisions to ensure that there are not unintended incentives to encourage the use of emergency departments outside available office hours.

MONITORING

Most provinces with alternate funding arrangements for family physicians, including Ontario, request physicians to shadow bill for services included in their contracts in order to obtain information on the frequency and nature of physician services being provided. 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 by physicians paid through alternate funding arrangements. The Ministry informed us that although there is no reason to believe that physicians would forgo income available through shadow billing, it has no assurance that physicians actually do shadow bill for all patient services rendered. Therefore, the shadow billing data may not reflect all patient services provided.

As well, although the Ministry has some cost information, it has not tracked the full cost of each funding arrangement since the 2007/08 fiscal year. Therefore, the Ministry cannot compare the amounts paid for the services delivered by family physicians among the different alternate funding arrangements or compare the payments made to the medical services being delivered. It also cannot compare amounts paid under alternate funding arrangements to the amounts paid to family physicians who are remunerated solely through fee-for-service billings.

Further, some aspects of the alternate funding arrangement contracts are difficult to monitor, such as whether physicians invite all of their patients to enrol with the group or whether physicians refuse to enrol certain patients when they switch to an alternate funding arrangement. This information would assist the Ministry in determining whether the more costly alternate funding arrangements are meeting its goals.

In addition, without good information on the relative costs and service levels being provided, it is more difficult for the Ministry to effectively negotiate with the Ontario Medical Association to make changes to alternate funding arrangements that

would better enable the Ministry to meet its goals, or to consolidate the current funding arrangements. The Ministry informed us that its initial focus was on encouraging as many family physicians as possible to join an alternate funding arrangement, in order to improve patient access, provide income predictability for physicians, and better predict Ministry expenditures. The Ministry indicated that it plans to increase its monitoring of these arrangements now that more than 60% of family physicians are participating.

RECOMMENDATION 5

To provide the Ministry of Health and Long-Term Care (Ministry) with information that would facilitate better monitoring of the benefits and costs of each alternate funding arrangement for family physicians, the Ministry should:

- periodically review shadow billing data to determine the frequency and nature of services provided by physicians in each arrangement;
- track the total amount paid to physicians participating in each arrangement; and
- track the average amounts paid to each physician both for reasonableness and for the purposes of comparing them to physician compensation under the traditional fee-for-service funding model.

MINISTRY RESPONSE

The Ministry supports the recommendations for improved monitoring of alternate funding arrangements. The Ministry recognizes that increased monitoring of the contracts will better ensure the achievement of the Ministry's goals and objectives in relation to the alternate funding arrangements, and the Ministry will implement the monitoring activities identified in the recommendations, as follows:

- introduce a process whereby shadow billed services by physicians in the Family Health Network and Family Health Organization

alternate funding arrangements will be reviewed to ensure that the volume and nature of the services are consistent with expected service levels and the services included in the contract;

- track total payments by model annually; and
- establish payment tracking at a physician level to compare base rate payments in the Family Health Network and Family Health Organization alternate funding arrangements with the fee-for-service equivalent, by using shadow billing claims data.