Ministry of Health and Long-Term Care

Funding Alternatives for Family Physicians

Follow-up to VFM Section 3.06, *2011 Annual Report*

Background

In the past, Ontario's family physicians were traditionally paid almost entirely on a fee-for-service basis from the Ontario Health Insurance Plan (OHIP) for providing medical services. Over the past 10 years, the Ontario Ministry of Health and Long-Term Care (Ministry) has significantly increased its use of alternate funding arrangements for family physicians in order to, among other things, improve patients' access to care and provide income stability for physicians.

There are 17 types of alternate funding arrangements for family physicians. Under many of them, 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 enrolled patient (that is, each patient who agrees to see the physician as his or her regular family physician). Physicians may bill for additional services, as well as for services to non-enrolled patients, on a fee-for-service basis (for a list of the types of payments physicians can receive, see Figure 1). As was also the case at the time of our 2011 audit, the Family Health Group (FHG), Family Health Organization (FHO), and Family Health Network (FHN) arrangements account for more than 90% of family physicians in alternate funding arrangements and more than 90% of enrolled patients.

Alternate funding arrangements are generally established and modified by the Physician Services Agreement between the Ministry and the Ontario Medical Association (OMA), which bargains on behalf of physicians in Ontario. This agreement specifies the services that physicians must provide and the compensation that the province will pay for services rendered. Up to now, it has generally been negotiated every four years, but the latest agreement was for a two-year period only and therefore will be renegotiated in 2014.

By the end of the 2012/13 fiscal year, 8,100 of the province's 12,500 family physicians were participating in alternate funding arrangements (7,700 of almost 12,000 family physicians in 2010/11), and 10 million Ontarians had enrolled with these physicians (9.5 million in 2010/11). Of the $4.2 billion in total payments made to the province's family physicians in 2012/13 ($3.7 billion in 2009/10), $3.4 billion was paid to physicians participating in alternate funding arrangements (more than $2.8 billion in 2009/10), with $2.2 billion of this amount related to non-fee-for-service payments, such as annual capitation payments ($1.6 billion in 2009/10).

In our *2011 Annual Report*, we found that most family physicians participating in alternate funding

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

arrangements in 2007/08 were being paid at least 25% more than their counterparts in the fee-for-service system. By 2009/10, the 66% of family physicians who participated in alternate funding arrangements were receiving 76% of the total amount paid to family physicians. The Ministry had not tracked the full cost of each alternate funding arrangement since 2007/08, or analyzed whether the expected benefits of these more costly arrangements had materialized.

Some of our other significant observations included the following:

- Based on a survey it commissioned, the Ministry estimated that various initiatives, including alternate funding arrangements, had 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. Although 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.
- 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 $123 million just for having these patients enrolled. Furthermore, almost half of these patients visited a different physician, and OHIP also paid for those visits.
- The annual capitation fee for each patient enrolled in an FHO could be 40% higher than the annual fee for patients enrolled in an FHN, because almost twice as many services were covered under FHO arrangements. Nevertheless, in 2009/10, 27% of all services provided

to FHO patients were not covered by the arrangement, and the Ministry paid an additional $72 million to 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 include coverage for these and other relatively routine medical services.

We made a number of recommendations for improvements and received commitments from the Ministry that it would take action to address our concerns.

Status of Actions Taken on Recommendations

The Ministry provided us with information in the spring and summer of 2013 on the current status of our recommendations, indicating it had made some progress in implementing the recommendations in our *2011 Annual Report*. For example, the Ministry has started to periodically monitor whether physician groups are meeting their after-hours service requirements. However, it will take longer to implement most other recommendations, such as monitoring the frequency and nature of physician services provided to patients, tracking the average amount paid to a family physician participating in an alternate funding arrangement, reviewing the impact of enrolment size on patient access to care, and reviewing the impact of existing financial incentives on hard-to-care-for patients. The Ministry and the OMA have agreed to conduct a number of joint studies to look at many of our concerns regarding patient access to care. They expect to complete the studies by April 2014 to inform the negotiations between the Ministry and the OMA in 2014.

The status of the actions taken on each recommendation is described in the following sections.

ESTABLISHING ALTERNATE FUNDING ARRANGEMENTS

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 (OMA) 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.*

Status

The Ministry has started a formal evaluation of the two main alternate funding arrangements: the Family Health Groups (FHGs) and Family Health Organizations (FHOs). The evaluation is expected to measure the effectiveness of the models against identified objectives and establish baseline information on the performance of FHG and FHO models in comparison to the traditional fee-for-service model. The evaluation is expected to include a comprehensive jurisdictional literature review, analysis of data from the claims-payment system, and surveys of patients and physicians. At the time of our audit, the Ministry told us that work was under way on the first two components of the evaluation (literature review and data analysis), and that it was considering using its new Health Care Experience Survey to obtain the views of patients and physicians. The Ministry expects to complete the evaluation by January 2014.

The Ministry also said it will continue the practice of fully costing any new alternate funding arrangements, and any amendments to existing arrangements, prior to negotiations. Since our audit, there have not been any new types of alternate funding arrangements. The Ministry informed us that, for the purpose of negotiating the 2012 Physician Services Agreement with the OMA, it prepared a series of proposals on various aspects of alternative funding arrangements for family physicians. These proposals were designed to simplify or reduce the different types of payments under the contracts, achieve savings, better define service expectations and performance measures, and improve access to care and quality. In most cases, these proposals contained information on the expected costs of the proposed changes. Changes made to the 2012 Physician Services Agreement as a result of these proposals are referred to throughout this status update where appropriate.

The Ministry also informed us that it has refined its registration procedures to include a checklist of all documentation required, including signed contracts and declaration forms, prior to commencing funding to physicians under alternate funding arrangements. This process should help ensure that signed contracts and declaration forms are in place for new arrangements or for physicians joining existing arrangements. The Ministry told us that it did not ensure signed contracts or declaration forms were in place for existing physicians.

ENROLLED PATIENTS

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.*

Status

The Ministry informed us that it plans to review its policies regarding:

- the appropriateness of paying capitation payments for enrolled patients who do not visit the physician with whom they are enrolled for at least 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 enhanced/modified payment incentives are required to ensure continued access to care.

The Ministry has identified the data and resources needed to perform the reviews, but has not yet extracted the data to begin the analyses. The Ministry advised us that any proposed changes resulting from the policy reviews would have to be negotiated with the OMA, either as part of the next round of negotiations for the upcoming 2014 Physician Services Agreement, or through the contract amendment process set out in the current 2012 Physician Services Agreement.

In the Ministry's 2011 response to our audit recommendation, it indicated that work was underway by a joint ministry/OMA working group, with support from the Institute for Clinical Evaluative Sciences, to evaluate options for modifying the capitation rate in order to resolve issues related to maintaining complex patients in capitation-based funding models (the rate currently only takes into

account the age and sex of a patient). The study formed the basis for an interim acuity modifier included in the 2012 Physician Services Agreement, which is mentioned in the next recommendation. The Ministry informed us that it expects to negotiate a permanent acuity modifier in the next round of negotiations with the OMA.

PATIENT ACCESS TO PRIMARY-CARE 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.*

Status

At the time of our follow-up, the Ministry had implemented an annual monitoring process to evaluate the provision of after-hours services by family physicians in alternate funding arrangements, and had developed a process to encourage non-compliant physicians to take corrective action. Contracts define "after-hours" as Monday to Thursday after 5 p.m. and anytime from Friday through Sunday. At the time of our audit in 2011, the Ministry conducted an ad hoc review of claims for after-hours services submitted by FHNs, FHOs and FHGs for June 2010 to determine whether physician groups had complied with the after-hours service requirements. The Ministry informed us that it repeated the exercise for June 2011 and June 2012 and found that there has been a slight improvement in compliance rates over the last two years, as illustrated in Figure 2. An exemption from providing after-hours services can be obtained from the Ministry if more than 50% of physicians in the group provide certain other services outside regular hours, such as emergency room coverage. The Ministry advised us that, since 2011, it has required all physician groups who meet exemption criteria and wish to be exempt from providing after-hours service to re-apply annually for the exemption to ensure they continue to be eligible for it. According to the Ministry, over the last two years there has also been an almost 40% increase in the number of FHOs required to perform after-hours services, which is likely to improve access to services, and virtually no change for FHGs and FHNs.

The Ministry advised us that it had completed an inventory of all current contract requirements in the FHG and FHO alternative funding arrangements, and had assessed the impact associated with each contract requirement in terms of financial risk and risk to patient access. The Ministry's evaluation identified two contract requirements as high risk, for which the Ministry had no monitoring processes in place. One was physician services (the ability, for example, to provide patients with comprehensive medical care) and the other was maintaining regular business hours. The Ministry informed us that developing monitoring processes for these two areas are a priority, and that it expects to have them in place by January 2014.

According to the Ministry, improving patient access to primary care services was a key theme in the 2012 negotiations with the OMA. To that end, the 2012 Physician Services Agreement includes a

Figure 2: Percentage of Physician Groups in Compliance with After-hours Services
Source of data: Ministry of Health and Long-Term Care

Funding Arrangement	June 2010 (%)	June 2011 (%)	June 2012 (%)
FHG	75	79	76
FHN	41	57	50
FHO	60	72	62

number of provisions to improve access to family physicians, such as:

- bonuses to encourage more house calls;
- implementation of an interim acuity modifier in capitation payments to take into account the seriousness of a patient's medical condition; and
- enhanced after-hours service requirements for groups with more than 10 physicians. For example, under the 2012 agreement, practices with 10 physicians are required to provide a minimum of seven three-hour blocks of after-hours services each week, while practices of 100 physicians must provide 20 three-hour blocks. Under the previous agreement, all practices of more than five physicians were required to provide a weekly minimum of only five three-hour blocks.

The Ministry intends to monitor house calls through fee-for-service claims and/or shadow billings, and the enhanced after-hours services for large groups through the annual monitoring process described above. Since the acuity modifier is a one-time calculation and payment, no monitoring activity is expected.

The 2012 Physician Services Agreement also included commitments by the Ministry and the OMA to conduct two joint studies related to patient access to primary care physicians, as follows:

- a study of daytime access to primary care physicians in the various alternate funding arrangements, including recommendations on possible guidelines on daytime operations that could include standards for group size, and strategies and support for same-day or next-day access; and
- a policy review to consider the value of access bonuses (the amounts deducted from capitation payments to physicians in FHNs or FHOs when their enrolled patients seek non-emergency treatment outside the practice), the impact on emergency departments, exemption for urgent care centres and GP-focused practices, and the impact of walk-in clinics.

Both studies are to be conducted by a joint committee of the Ministry and the OMA that is expected to report back by April 2014. The Ministry informed us that it would consider recommendations from the two joint studies in developing proposals for the 2014 round of negotiations with the OMA.

PAYING FAMILY PHYSICIANS

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.*

Status

The Ministry advised us that during the 2012 negotiations with the OMA, it proposed moving towards a single capitation payment model that would cover more clinical services than before. It also proposed to simplify the types of payments under the various contracts. However, negotiations with the OMA did not result in any changes in the number of arrangements, nor in the list of services covered under each type of arrangement.

The 2012 negotiations with the OMA did, however, result in some changes in the types of payments made to physicians. According to the 2012 Physician Services Agreement, some types of

payments were eliminated for all types of funding arrangements, while other types of payments were eliminated for only some arrangements. Overall, this reduced the number of different types of payments to physicians in FHGs to 37 from 42, and to physicians in FHOs to 52 from 61.

In addition, the Ministry told us that it plans to initiate a review of all bonus and premium payments under the various contracts to identify opportunities to further simplify payments. It expects to use the results from this review to propose changes to the OMA in 2014.

With regard to the issue of physicians being paid a capitation rate for patients they seldom or never see, the last round of negotiations with the OMA did not result in a reduction in capitation rates for these patients. Instead, the Ministry hopes to establish an acuity modifier that will address service utilization under the capitation-based payment models. The last round of negotiations also did not produce an increased penalty in capitation payments (that is, the access bonus) to physicians when their enrolled patients seek non-emergency services from outside the practice. As noted in the previous recommendation, the Ministry and OMA have committed to jointly conduct a policy review of the access bonus payment for capitation-based models like FHNs and FHOs. In its 2011 response, the Ministry stated that a similar review was under way at that time. However, it was put on hold once negotiations started with the OMA.

MONITORING

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.*

Status

At the time of our follow-up, the Ministry was still in the process of developing monitoring activities that would address the recommendations above and support future program or policy design changes for capitation-based models, including FHNs and FHOs. The Ministry informed us that it had identified its data needs and extracted data for initial analysis, and was in the process of developing regular production reports for payment tracking and analysis. The Ministry expects regular production reports to be developed by late autumn 2013 and regular monitoring activities to begin soon after.