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Communiqué

for Health Industry Clients
on the Legal Retainer Program

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Emergency Department Alternate Funding Agreements

The Ministry of Health and Long Term Care (the "**MOHLTC**") has now released the next iteration of the Emergency Department Alternative Funding Agreements ("**ED AFA**") for public hospitals. Both of the new ED AFAs are to run until March 31, 2004. There are two models:

- The *Permanent 24-Hour ED AFA*, for hospitals with less than 30,000 visits; and
- The *Workload ED AFA*, for larger hospitals with more than 30,000 visits.

The two new ED AFAs do not differ materially from the previous form of the ER AFA model. The parties to the ED AFAs include the Minister, the Hospital, the physicians who make up the ""Emergency Group" and the Ontario Medical Association (the last, solely for the purpose of dues collection).

Features common to both ED AFAs

New features that are ***common*** to ***both*** of the new ED AFAs are the following:

(a) Both ED AFAs provide that the Minister will provide only $20,000.00 in connection with administrative expenses related to the provision of the Emergency Services. That sum is also to be used by the Hospital in a manner that is ***mutually acceptable*** to the Hospital and to the Emergency Group. Attendees at the ED AFA Information Session held by the Ministry were told that the Ministry's Health Care Programs Division had earmarked a portion of Hospitals' global budgets for the administration of Alternative Payment Plans.

(b) With a view to eliminating the confusion over scheduled and unscheduled visits to the ED and billing practices, both ED AFAs include a definition for a "Scheduled Visit"*. Under the Permissible Claims inside the Emergency Department, the ED AFAs now provide that claims to OHIP may be made for services provided during Scheduled Visits, provided that the physician is not being paid under the ED AFA at the time of rendering the service. The Ministry's intention of course is to avoid paying twice for the same service: once through OHIP and once under the ED AFA. Scheduled Appointments must be made at least 24 hours before providing the service.

(c) Both ED AFAs permit physicians who are being paid under the ED AFA to bill fee-for-service ***outside of the Emergency Department*** where the physician "is requested by a nurse to urgently attend to a seriously ill in-patient and waiting for the patient's most responsible physician would endanger the patient's health". The ED AFA requires that the request by the nurse must be documented in the patient's medical/hospital record. Accordingly, hospitals may wish to develop policies:

(i) ensuring that the most responsible physician ("**MRP**") is clearly identified in patient charts;
(ii) providing that if the nurse calls the MRP who asks the nurse to contact the Emergency Department physician, that the nurse document the physician's request on the patient chart;
(iii) providing that in certain *critical* situations, the nurse is directed or required by applicable medical directives or protocols to call the Emergency Department physician.

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*"*Scheduled Visit*" means a planned visit by an Insured Person either to the Emergency Department if no Out-Patient Clinic is available or open at the Hospital, or to the Out-Patient Clinic at the Hospital. An appointment must have been made at least 1 calendar day prior to rendering the service. No special visit premium to the Emergency Department shall be billed to the Plan for Scheduled Visits. [subsection 1.1, *Definitions*, of the ED AFAs].

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(d) Both ED AFAs require that Hospitals report and submit Canadian Triage Acuity Scale data and National Ambulatory Care Reporting System ("**NACRS**") data to the Minister. If the Hospital fails to provide NACRS data to the Minister concurrently with its transmission to the Canadian Institute of Health Information, the Hospital will be obligated to make financial contributions towards the cost of providing the Emergency Services.

(e) Both ED AFAs provide slightly greater guidance in connection with governance arrangements for physician groups. Physician partnerships and unincorporated associations composed of physicians will be allowed to enter into the ED AFAs (this of course assumes that professional corporations will not become contracting parties to ED AFAs).

(f) Both ED AFAs determine Hospital volume levels on the basis of 2000-2001 shadow billing data, if applicable, or 2000-2001 fee-for-service billings to the Plan with certain adjustments.

(g) Both ED AFAs provide that no other funding to physicians for emergency services in that hospital is permitted and hospitals may not pay physicians more than outlined in the ED AFAs (except for payment for management functions, etc.). Hospitals are also precluded from seeking funding from ED groups for any costs related to the provision of emergency services.

(h) Both ED AFAs introduce the concept of a GP Expert, a general practitioner who provides specialist services in the ED, who is not paid under the ED AFA but who bills the Plan on a fee-for-service basis.

Features unique to each model

24-hour ED AFA

This ED AFA is designed for hospitals that have less than 30,000 visits to the ED annually. Funding is based on 2000-2001 shadow billing data, if applicable, or 2000/2001 fee-for-service billings to OHIP.

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This ED AFA also includes the following:

(1) provision for a Second On-Call Physician who may be called in to the ED in accordance with certain protocols that must be established. This Physician may bill fee-for-service for services provided in the ED during such times, up to an annual maximum determined by reference to annual ED visit volumes;

(2) for participating physicians in hospitals with an ED volume of less than 17,500:

(a) such physicians may be on call from outside the ED provided that they are available within pre-arranged time frames;

(b) such physicians may bill fee-for-service for scheduled out-patient clinic visits of a non-emergent nature, despite being on duty and being paid under the ED AFA.

Workload model ED AFA

This ED AFA is designed for larger hospitals that have more than 30,000 visits to the ED annually.

There has been some modification of the funding process under this AFA with the introduction of new terms such as “Average Coverage Hours” and Quarterly Reviews.

Additional considerations

(1) The writer is informed that transitional provisions to assist the parties in moving from the Interim ER AFAs to the new ED AFAs are currently under development.

(2) ***In smaller communities, it is unclear how the overlapping relationship between family health networks and emergency groups will be harmonized. Although the two working groups of the Physician Services Committee, responsible for Primary Care Reform and the ER AFA, were aware of each other, it is unlikely that the contracts are necessarily compatible without further modification.***

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Note: This communiqué is provided as an information service to our clients and is a summary of current legal issues of concern to Health Industry Clients. Communiqués are not meant as legal opinions and readers are cautioned not to act on information provided in this communiqué without seeking specific legal advice with respect to their unique circumstances. Your comments and suggestions are most welcome and should be directed to Kathryn Frelick, Coordinator, Legal Retainer Program.

(3) At the current time, the ED AFA reflects the government's intention to keep physicians as independent contractors, and not as employees.

(4) The relationship between Hospital On-Call Coverage funding and the ED AFAs is supposed to fit and work together. However, it is possible that there may be some overlap depending on the pre-existing HOCC arrangements, if any, between hospitals and their on-call physicians.

Miller Thomson LLP and Miltom Consulting would be pleased to assist you in determining whether the ED AFA is desirable in your circumstances, in managing transition or implementation issues, or in addressing any questions or matters that may arise in the course of the management of the ED AFA.

About the Author:

Alan Belaiche is a lawyer practicing in our Health Industry Practice Group. As a member of the negotiating team for the Ministry of Health and Long-Term Care on the provincial primary care reform project, Alan has acquired an in-depth understanding of medical and public hospital operations and alternative payment plans.

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