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Ontario Medical Association: Section on Emergency Medicine  
Executive Communication # 4  
October 3, 2008

**2008 Tentative MOH/OMA Contract**

Your Section Executive has had the opportunity to review the tentative 2008 MOH/OMA Physician Services Contract. Full details of the agreement are available by clicking on the link: <http://www.oma.org/shared/agreement.pdf> on our Section's web page, <http://www.oma.org/shared/SEMCom3ExecSummary.pdf> <https://www.oma.org/Members/Sections/emerg/index.htm> as well as historical information on fees and our prior submissions to the OMA Negotiation Committee. We encourage members to attend the various OMA updates throughout the province for more information. We would like to review the salient points of the contract as they apply to our members who provide emergency department (ED) care.

The agreement is divided into two basic categories: Fee increases and Program initiatives. There will be approximately 1.1 billion dollars of increased *base* funding over the four year term of the agreement. 861 million dollars is earmarked for increased fees. This is equivalent to a 12.25% increase in *base* funding by the end of the agreement. 240 million dollars is earmarked for special program initiatives. This is equivalent to a 3.4% increase in base funding for programs by the end of the agreement.

The General Fee Increase during the period October 1, 2008 until September 30, 2009 will be 3%. This means that all professional services rendered during this time period will be paid at 103%. Effectively, this means there will be a 3% across the board increase in *all* Schedule of Benefit professional billings, automatically, *but only for this time period*. There is a non-retroactive 3% increase in payment to physicians (Note: SOB will remain unchanged) from Oct 1, 2008 until Sept 30, 2009. Thus the period April 1, 2008 to March 31, 2009 only will see a 1.5% increase in cash flow and no go forward compounding.

Effective October 1, 2009, the 3% increase referenced above will be re-allocated by a new, joint MOH/OMA committee, called the Physician Services Payment Committee (PSPC). The PSPC will take the 3% in addition to a 2% fee increase effective October 1, 2009. As per section 3.2 of the agreement, the PSPC will then globally increase the OHIP Schedule of Benefits, per the following timeline: increases of 5% on October 1, 2009, 3% on October 1, 2010, and 4.25% on September 1, 2011. One half of the increase in each year will be allocated on an equal percentage basis to each OHIP *specialty*. The other half of increases will be allocated to *OHIP Specialties* (emphasis added) by the PSPC, based upon a relativity methodology. This methodology will be developed over the year leading up to implementation through the RVIC Methodology Review Working Group being struck by the OMA Board and agreed to by the OMA and MOH (discussion to follow).

The rate of increases noted above shall flow through to the MOH Alternate Payment Plans and Alternate Funding Plans, excluding administrative and non-clinical payments. The basis of

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the flow through is to achieve comparable economic increases as the physicians paid fee for service.

In terms of the General Fee Increases, the Section has several important concerns with respect to any relativity adjustments. Namely:

- The OMA Section of Emergency Medicine had to be excluded from prior Relative Value Implementation Committee model due to the use of a very small sample size -- composed only of FRCP (EM) physicians -- rendering the data unreliable.
- The Section is concerned about several critical methodology issues, such as the inability of the models to value unsociable hours care in EDs, the inability of the model to recognize that both members of the specialty of General and Family Practise as well as the specialty of Emergency Medicine provide ED care, and the reliance on total income ratios of General Practise versus Specialties
- Currently, without a clear understanding of the methodology and how relative value differences will be implemented, it is impossible to predict where the Section will fall along the relativity ladder
- If past RVIC analyses are utilized, the Sections that stand to make the greatest gains on October 1<sup>st</sup>, 2009 are Paediatrics, Psychiatry, Physiatry and Neurology. Sections that stand to receive the lowest estimated fee increases include Anesthesia and Ophthalmology. See more details in the Tentative 2008 Physician Services Agreement Backgrounder: Sectional Allocation Calculation and Process [http://www.oma.org/shared/Fee\\_Increase\\_Allocation.pdf](http://www.oma.org/shared/Fee_Increase_Allocation.pdf). The proposed PSPC will consist of an as-yet unspecified number of members. 50% of its members would be selected from the OMA membership by an as-yet unspecified process and set of criteria. Furthermore the distribution of specialties within the PSPC is unspecified. Lastly there is no indication that the OMA would have any input into the selection of the remaining 50% of PSPC committee membership: it would be derived from and selected by the MOHLTC
- Neither the Relative Value Implementation Committee members from the OMA/MOH nor the Physician Services Payment Committee Members from the OMA/MOH have been chosen
- Even if the Section on Emergency Medicine receives a substantial relativity allocation, the decision on how and exactly where to apply the fee increases to the Schedule of Benefits *will ultimately lie with the PSPC*. The Section will provide input to this process only.
- Where fees cross Sectional lines, allocations may have to take place on a complicated code by code basis.
- Recently, the Central Tariff Committee discounted an agreed upon increase to Life Threatening and Other Resuscitation codes G521, G523, G522, G395, and G391. The CTC agreed to enhance the existing codes then discount them by nearly 16% based upon incomplete, outdated and indirectly measured overhead data from 112 alleged full time, fee for service FRCP(EM) physicians who only comprise 2.6% of the physicians who actually bill these codes.

Another key issue with this agreement is that there is *no funding* to implement past or pending Central Tariff Committee Decisions. This summer, the Section has *finally* made

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significant headway in obtaining recognition by the CTC that the Section on Emergency Medicine *deserves*:

- Unsociable Hour Procedure Premiums at a rate of 20% on evenings and weekends, and 40% on overnights.
- Geriatric Assessment Premiums for ALL Emergency Department H codes (15% applicable to all patients over the age of 65)
- Substantial increases to Life Threatening Resuscitation Codes.

Of note, the decisions of the 2008 CTC must be ratified by OMA Council in November to take effect. The Section is also appealing several CTC decisions in order to remove presumed overhead clawbacks, to increase all the key ED H assessment codes, and to obtain a percentage based premium for H112/H113 codes. Unfortunately, if there is no funding for these CTC decisions, the net benefit of having successfully argued for the fair application of geriatric premiums and unsociable hours procedure premiums is NIL. The Section would have to use its allotted annual fee increases, after a relativity adjustment, to *either*:

- a) Request the implementation of a CTC decision or
- b) Request an increase to an existing code or
- c) Request any combination of the above, to the limits of the allotted percentage increases

In short, we will not receive all the direct benefits of geriatric premiums which we fully deserve as there is no commitment to fund these CTC recommendations. General and Family Practice A007 and A003 codes are of course already subjected to geriatric premiums and as such, the premium is grandfathered to these codes. Similarly, we will not receive all the benefits of longstanding deserved unsociable hour procedure premiums as there is no commitment to fund these CTC recommendations. All physicians providing in hospital procedures have received a 50% premium on evenings and weekends, and a 75% premium on overnights. These premiums are grandfathered to all in hospital unsociable hour procedure codes except for procedures performed by emergency physicians on duty.

As we noted in our Communication in April of 2008

<http://www.oma.org/shared/SEMCom3ExecSummary.pdf>

- The Section on Emergency Medicine believes the *fundamental cause* of the ongoing emergency physician shortage in Ontario is the poor remuneration for the delivery of emergency services under the Schedule of Benefits (SOB) and the correspondingly weak remuneration rate under the emergency department alternate funding arrangement (EDAFA).
- Emergency Medicine received the **lowest** increase amongst clinical sections in the previous OMA-MOHLTC agreement.
- Emergency Medicine received an increase that was **12.7% less** than the average increase and **20.1% less** than the General Practice increase.
- **The Ontario emergency department assessment (H) codes are on average 63% behind equivalent codes in British Columbia, Alberta and Saskatchewan.**
- Addressing these deficiencies directly through increases to the Schedule of Benefits is the only effective and durable solution to the chronic and recurring ER staffing crisis in Ontario.

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**LHIN ED Collaboration Initiative:**

The tentative agreement allots *up to* (emphasis added) \$ 14 million dollars as an incentive initiative to recognize ED physicians at the LHIN level whose LHIN hospitals meet the following goals:

- a) *All* the EDs at hospitals in a LHIN did not close for *any* period of time over the course of the year due to physician staffing issues.
- b) *All* the EDs at hospitals in a LHIN achieved the wait time benchmarks established by the ED expert panel for CTAS IV and V patients.

This part of the agreement is particularly troublesome. Physicians who may be working triple overtime and sacrificing their health and family lives may see this incentive evaporate based on a short closure in any hospital in their LHIN. Also, achieving wait time targets, even for CTAS IV and V patients is often outside of physician control because of continued overcrowding and bed block. One institution in the GTA recently recorded 50 Left Without Being Seen Patients in a day due to a 12 hour wait time. Most of these had lower CTAS scores. Thus, instead of appropriately awarding individual physician sacrifice and productivity, we will be subjected to unachievable incentives beyond our control. Up to \$14 million dollars of LHIN money is guaranteed to go to physicians. There will a bi-lateral process to determine how the funding will flow

The tentative agreement will see a 30% increase in all the major inpatient MRP codes (such as C123, etc). Unfortunately, C004 and H105 are the most common codes billed by physicians on duty in the ED and these are not subject to any specific increases. Of course, the real point is that the ED physician is the MRP for ALL patients who are admitted to Ontario hospitals from the time a patient is assessed in the ED until the time the patient is physically seen and assessed by the admitted patients attending physician. We are the *de facto* MRPs for the first part of all inpatient stays and are continually not recognized or appropriately compensated for this responsibility. Why were we excluded from fee increases for commonly billed codes that carry inpatient responsibility?

It would have been very simple to target a specific fee increase to all Emergency Department H codes in order to address the current *gross inequities* in ED fees which are widely recognized by other Sections and Board Members. This was not done. We do not know why this was not done. However, time and again, we have consistently advised that the continued grossly inadequate funding of emergency physician services will erode the delivery of emergency services to the point of collapse. It will be impossible to recruit and retain emergency physicians if this agreement passes without specific and immediate enhancements for ED services.

Furthermore, the Section has been informed that there is growing concern amongst LHIN ED Leads that ongoing and growing imbalances in competitive funding will lead to more family doctors and ER doctors leaving their ER practices in favour of more lucrative family practice incentives. The Section Executive believes that this will place increasing pressure on already critically strained physician reserves, and will lead to more ER closures next summer. It is the intent of the Section Executive to provide written notice of these concerns to the OMA leadership and the provincial government immediately, so that our concerns at this time can be on the public record. We feel that this is contradictory to the OMA public message being advertised on the OMA website

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[www.moredoctors.ca](http://www.moredoctors.ca). It is also contrary to the public position of the Ontario government to ensure open ER's and access to all Ontario citizens.

The MOH and the OMA expect the Agreement "to deliver clear and measurable change in two priority areas: access to family health care for all Ontarians, and reducing congestion in Emergency Departments". The re-invention of a nebulous relativity process will *not* reduce congestion in Emergency Departments.

The current agreement, even if the Section on Emergency Medicine scores well in relativity modeling, will at best keep up with cost of living adjustments. *There is nothing in the tentative agreement that specifically targets the immediate and critical need for a substantial ED fee increase*

**For these reasons, the Section on Emergency Medicine Executive unanimously recommends that all Section members vote AGAINST the ratification of this Tentative Physician Service Agreement.**

Sincerely,



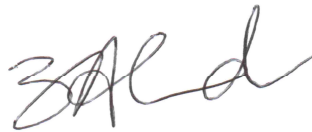
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