

BACKGROUND

- 10.1** The Canada Health Act establishes conditions and criteria for insured health services required to be provided by the provinces. In Nova Scotia, the Health Services and Insurance Act governs the provision of insured services. The Act and its related regulations prescribe the insured physician services residents are entitled to receive and the payment plans associated with delivering these services.
- 10.2** Insured services under the Medical Services Insurance (MSI) plan are generally defined as services rendered by physicians which are medically required or which are deemed to be medically required. Certain dental-surgical procedures provided in hospitals are also insured. Medically required services are those provided for the purpose of maintaining health, preventing disease or diagnosing or treating injury, illness, or disability. In addition to the basic insured services provided under the MSI plan, the Province also provides limited coverage for vision care to children and seniors, a special dental program for certain client groups, and a children's dental plan.
- 10.3** All residents of the Province, with the exception of members of the RCMP or Canadian Armed Forces, NATO employees and inmates in federal penitentiaries are entitled to receive insured services. For the year ended March 31, 2005, Provincial payments for insured medical services and related expenditures totaled \$500.5 million (see Exhibit 10.1).
- 10.4** The Health Services and Insurance Act gives the Minister of Health responsibility for negotiating payments for physician services. The Nova Scotia Department of Health (DOH) negotiated an agreement with Doctors Nova Scotia (formerly the Medical Society of Nova Scotia) for the period from April 1, 2004 to March 31, 2008. In addition to specifying medical practitioner compensation levels on a fee-for-service basis, the agreement also provides for negotiation of alternate funding arrangements. Compensation for insured dental services is addressed in the Insured Dental Services Tariff Agreement which is effective for the same time period.
- 10.5** Approximately 55% of physicians in the Province are paid solely under a traditional fee-for-service arrangement. Certain physicians, primarily specialists, have opted to be paid on an alternate funding basis (entirely fixed fee or a combination of fixed fee and fee-for-service), and therefore do not submit regular fee-for-service claims, but instead are required to submit shadow billings to facilitate monitoring of activity levels. In 2004-05, the Province made payments under alternative funding arrangements totaling \$178.2 million. In 1999-2000, when we last audited Alternative Funding, the payments totaled \$85.3 million. In the last five years, the cost of alternative funding arrangements more than doubled (see Exhibit 10.1).

10.6 We audited Physician Alternative Funding Initiatives in 2000 (2000 Report of the Auditor General, Chapter 9) and followed up on our findings in 2003 (2003 Report of the Auditor General, Chapter 10). Our prior reports are available at <http://www.gov.ns.ca/audg>. In 2000, our major observations were as follows:

- While Alternative Funding Initiatives may have potential benefit to the health care system, conditions giving rise to specific initiatives and the outcomes expected were generally not well articulated.
- There were deficiencies in the systems providing for due regard for economy and efficiency, including infrequent evaluation of outcomes and incomplete shadow billing data on the volumes of services provided.
- There were weaknesses in certain controls over compliance with contracts.

RESULTS IN BRIEF

10.7 The following are the principal observations from our 2006 audit.

- The 2005 agreement between the Province and Medavie Inc. for administration of the Medical Services Insurance Plan is a major improvement over the one it replaced. For example, Medavie is now required to provide annual audited financial statements of Medical Services Insurance program costs to the Department of Health. This represents a significant improvement in accountability for this major government program area.
- In April 2006, the Labour Relations Committee of Executive Council accepted the general direction of a new framework for physician alternative funding arrangements proposed by the Department of Health. The proposed framework incorporates improvements in accountability and a blended compensation base including fee-for-service for clinical work and a fixed component for non-clinical activities. Previous alternative funding arrangements generally did not include a significant fee-for-service component. As at the time of writing this Report, no alternative funding agreements had yet been signed under the new framework but negotiations were in progress.
- We examined a sample of existing alternative funding agreements and concluded that there was a general lack of accountability. The deliverables have not been well defined in certain contracts, the contracts generally lack strong reporting requirements and the documentation included in the negotiation files needs to be improved.
- All new and renewed alternative funding contracts must receive Executive Council approval as required under Section 59 of the Provincial Finance Act. The Department was only able to provide such approvals for three of the eleven contracts in our sample. The Department of Health should ensure

that all contracts receive Executive Council approval and documentation of the approvals should be maintained to preserve a trail for management and auditors.

- In 1997, the Department of Health decided to pay physician services claims for patients with expired health cards which compromises the effectiveness of the beneficiary registration process and increases the risk of paying claims related to ineligible patients. In 2003, we recommended that the Department of Health review the risks of accepting expired health cards and implement appropriate controls. No action has been taken on our recommendation.
- We tested the controls surrounding the registration process for providers of health services and found them to be adequate. The Department of Health's written policies governing the provider registration process do not reflect current practices and should be updated.

AUDIT SCOPE

10.8 The objectives of this audit were to:

- review the new agreement between the Province and Medavie for administration of the MSI plan;
- assess whether the systems and processes surrounding Alternative Funding Agreements provide for administration of this program area with due regard to economy and efficiency;
- assess compliance with Alternative Funding Agreements and the adequacy of accountability mechanisms and performance measurement;
- review the controls over the beneficiary registration system and assess compliance;
- review the controls over the provider registration system and assess compliance; and
- review the audit planning performed by the Monitoring & Statistics Division of Medavie Inc. related to physician payments and the results of its audit activities.

10.9 Audit criteria used to assess the subject matter were primarily based on *Principles for Negotiating Alternative Funding Contracts* agreed to by the Department of Health and Doctors Nova Scotia, the Nova Scotia Department of Health's policies and the Canada Health Act.

10.10 Our audit approach was based on interviews, review of documents, analysis of data and testing of transactions for compliance. We interviewed representatives of the Department of Health and Medavie and examined various alternative funding agreements and other documentation. In addition, we obtained electronic copies

of the individual beneficiary registration database, the provider registry database and the claims database for the 2004-05 fiscal year. We used data extraction software to analyze the data and draw a sample of transactions for further testing. Our audit of controls was limited to controls over the manual processes; we did not review either computer environment or application controls.

PRINCIPAL FINDINGS

Contract with Medavie Inc.

10.11 The Department of Health had an agreement with Medavie Inc. (formerly Atlantic Blue Cross and Maritime Medical Care Inc.) to process and pay physician claims on behalf of the Department. The most recent agreement was signed in 1992 and extended several times. In 2000, the Department served notice to end the contract. DOH engaged external consultants to provide advice on a new contract. The consultants performed a “gap analysis” between DOH’s need for a performance-based contract and the existing contract. A new performance-based contract was established effective August 1, 2005 for the period to March 31, 2010 with provisions for renewal to 2015. The new contract is much more comprehensive than the one it replaced and includes various new accountability, service level and performance measurement requirements.

10.12 Some of the more significant features of the new agreement are as follows:

- DOH provides semi-monthly payments to Medavie for administration of all insured health programs, including both physician services and pharmacare. Payments include a fixed component and a component which varies on the basis of transaction volumes. Total payments for the first year of the contract are estimated to be \$10.4 million.
- New information technology systems for the programs will be developed. DOH is committed to pay \$15 million over ten years for this purpose.
- The information systems are the property of Medavie but a copy of the source code for the software systems will be placed in escrow to ensure availability to the Province in the event that Medavie ceases to operate.
- The agreement specifies service levels and financial penalties if breached.
- Required reporting from Medavie to DOH is extensive and details are specified in the agreement.
- There is an incentive for Medavie to identify costs savings in program administration. If Medavie identifies such an opportunity, it will share in the resulting savings.
- The Auditor General and the Department of Health have the right to perform audits of the administration of the agreement at Medavie.

- Medavie is obliged to provide copies of its annual audited financial statements to the Department of Health. It is also required to submit separate audited financial statements for the programs administered on behalf of the Province including operating costs and program payments.

10.13 In 2003, we had recommended that DOH ensure annual audit of medical payments by either the Department of Finance's Corporate Internal Audit group or external auditors. We note that the new agreement addresses our recommendation and is a major improvement in accountability for this significant government program area.

Alternative Funding Policies and Framework

10.14 **Background** – An alternative funding arrangement is intended to provide physicians with flexibility in the delivery of services by funding a range of activities. Depending on whether the contract is academic or non-academic, the services could include:

- clinical services;
- health promotion and disease prevention;
- administrative work;
- teaching; and
- research.

10.15 There are two types of alternative funding arrangements:

- **Alternative Payment Plans (APPs)** – Non-academic plans which are focused mainly on clinical outcomes.
- **Academic Funding Plans (AFPs)** – Academic plans which include academic medical teaching, research and academic leadership in addition to clinical work.

10.16 Nova Scotia claims to be leading the way with this new approach to compensating doctors. As of November 2005, nearly 45% of Doctors Nova Scotia's membership was remunerated partly or in full through alternative funding arrangements. This amounted to approximately \$178 million for 2004-05.

10.17 There are currently 30 separate alternative funding agreements in place in Nova Scotia. Agreements are made on a group or individual basis. One contract could represent from 1 to 150 or more physicians. Contracts are negotiated based on *Principles for Negotiating Alternative Funding Contracts* drafted by the Department of Health and the Medical Society of Nova Scotia (Doctors Nova Scotia).

10.18 In the early stages of alternative funding development, there was a prevailing lack of accountability. The *Principles for Negotiating Alternative Funding Contracts* document completed in May 2005 improved on the 1997 version.

- 10.19** **Policies** – DOH’s alternative funding policies were approved in late 1999 and have not been followed over the past few years. The policies have not been updated to reflect the new processes followed by the Department or the new framework initiative described in paragraph 10.20 below. Management has indicated that revised policies and a handbook for the AFP/APP programs will be completed as part of the framework project. The Department has not yet established a timeline for policy review. We believe that it is important for the policies to be updated as soon as possible to ensure a consistent approach to alternative funding arrangements.

Recommendation 10.1

We recommend that the Department of Health revise its policies for physician alternative funding arrangements to reflect current practice.

- 10.20** **New framework initiative** - In 2004 the Department of Health engaged consultants (North South Group Inc.) to complete a review on the alternative funding agreement with the Capital District Health Authority’s Department of Medicine, the Province’s largest Academic Funding Plan contract. The report was released in February 2005 and included 43 recommendations for improvement to the AFP negotiation process and contract requirements. The full report is available at <http://www.gov.ns.ca/health/downloads/Alternate%20Funding%20Audit%202004.pdf>
- 10.21** The following extract from the Executive Summary of the report (page v) summarizes the consultants’ conclusions on previous alternative funding arrangements.

“However, the audit did bring to light many important findings. As stated above, benefits of the AFP are noteworthy: the recruitment and retention of specialists in Nova Scotia has been effectively enhanced; the DOM academic program is considered to have been strengthened under the AFP; clinical care is said to be more rational and appropriate, with tertiary and quaternary specialists treating more acute and complex cases; the 16 divisions of the Department of Medicine are considered more viable and sustainable; the AFP has promoted increased multidisciplinary care provided by teams of health professionals, as well as more integration among specialty areas; clinical guidelines, a triage system, and a commitment to more evidence-based care have been developed. Quality of care is considered to have remained high; physicians are engaging in more health promotion and disease prevention; DOM specialists are able to engage in a balance of clinical and academic activities; and the AFP has contributed to a better lifestyle and work life quality for tertiary and quaternary specialists.

At the same time, serious weaknesses and challenges associated with the AFP have emerged. Most noteworthy is the lack of an accountability framework against which to measure performance and productivity of AFP-funded physicians. The lack of specific deliverables and performance targets has precluded the capacity of the auditors to measure the economy, efficiency and effectiveness of the AFP system. Furthermore, the lack of a clear determination of the clinical and academic ratio for the AFP physicians impaired the

capacity to assess value for money for the health care system, and to draw any meaningful conclusions from the financial audit over the contract term, as compared with similar expenditures under the fee for service system. Clearly, from the cross-Canada comparison undertaken by this study, it is evident that almost all jurisdictions are experiencing similar challenges in the administration of their alternative payment models. The administrative infrastructure to effectively manage AFPs is still evolving, and has not kept pace with the policy decisions of most ministries of health to implement these alternative systems.”

- 10.22** In February 2005, DOH presented the findings from the North South Group’s report to the Labour Relations Committee of Executive Council. The Committee directed that a working group be established to review the recommendations and establish a plan for implementation in collaboration with key stakeholders where appropriate. In May 2005, the Department created a multi-stakeholder steering committee to provide advice to the Department on alternative funding plans. Membership included:
- DOH;
 - Treasury and Policy Board;
 - Doctors Nova Scotia;
 - Dalhousie University Faculty of Medicine; and
 - the District Health Authorities and the IWK Health Centre.
- 10.23** The Department identified goals to be achieved through a new framework. The following goals were included in the March 30, 2006 framework presentation to the Labour Relations Committee of Executive Council:
- “Facilitates Innovative Care Delivery and medical education and research
 - Provides equitable, predictable/stable funding
 - Facilitates physician recruitment, retention, and allocation
 - Encourages collaboration
 - Facilitates provincial/regional program delivery
 - Helps achieve stakeholder goals
 - Facilitates Accountability and transparency
 - Ensure value-for-money”
- 10.24** The committee developed a framework model which, according to the Department of Health, addressed 41 of the 43 recommendations. Two recommendations were related to information technology and will require more time to introduce than the others. The framework was developed to serve as the model to be applied to all Alternative Payment Plan and Academic Funding Plan contracts to be negotiated in the future.
- 10.25** In early April 2006, the Department of Health made a presentation to the Labour Relations Committee of Executive Council on its proposed new framework and the Committee approved a number of related items. The Committee:
- accepted the general direction of the new framework, recognizing that it will continue to be developed;
 - approved the negotiating mandate for the renewal of an alternative funding

- plan for the Department of Medicine at the Capital District Health Authority;
- instructed DOH to develop the master contract for the AFP/APP framework as part of the negotiations respecting the Department of Medicine; and
- instructed DOH to report back to Executive Council prior to executing the contract with details on expected outcomes and measurements.

10.26 The key features of the new framework proposed by DOH are set out in Exhibit 10.3. The proposed framework, in contrast to previous arrangements, includes shared risk between the physician and the Department and more emphasis on volume of activities than previous agreements. The compensation base is blended and includes fee-for-service for clinical work and a fixed component for non-clinical activities. Each AFP/APP is to have an operations committee with a defined governance role involving funding and accountability. At the time of writing this Report (May 2006), the Province had not yet signed any agreements under the new framework.

10.27 The new AFP/APP framework includes the following two principles related to control of costs:

“Overall Compensation Equity Principle - Cost of AFP/APP should not exceed average NS FFS [fee-for-service] physician income for similarly qualified physicians.

Recruitment and Retention Competitiveness Principle - Costs beyond average NS FFS physician income may need to be accommodated in AFP’s in order to ensure the ability to recruit and retain given the national marketplace for academic physicians.”

Existing Contracts – Audit of Compliance

10.28 We examined a sample of existing alternative funding agreements to determine whether there was compliance with the agreements and whether the following criteria had been met:

- Alternative funding agreements should outline the specific services, activities and deliverables the group will provide.
- The specific human resources required to provide the negotiated services and activities should also be outlined in the agreement.
- To ensure the activities and services are provided as negotiated, accountability mechanisms should be in place.

10.29 Our sample consisted of 11 of the 30 existing agreements. Most of the agreements in our sample were negotiated in 2004 and expire on March 31, 2007. Our detailed findings are included in the following paragraphs. In summary, we reached the following conclusions.

- The documentation included in the negotiation files needs to be improved.
- The deliverables in certain contracts have not been well defined.

- There is a general lack of accountability within alternative funding agreements.

- 10.30** We also determined that there was no record of Executive Council approval of certain agreements as required under Section 59 of the Provincial Finance Act.
- 10.31** **Roles and responsibilities** - All agreements we reviewed had clearly outlined the specific human resources and professional qualifications required to provide the negotiated activities and services. The roles and responsibilities of all parties (DOH, District Health Authority, University, etc.) were clearly defined. Specific sections of each agreement were devoted to the various responsibilities of each party such as financing, governance or services.
- 10.32** **Contract approvals** - Section 59 of the Provincial Finance Act requires that all new and renewed alternative funding contracts receive Executive Council approval. The Department was only able to provide such approvals for three of the eleven contracts in our sample. There is no record of approval of the remaining contracts. The Department of Health should ensure that all contracts receive Executive Council approval and documentation of the approvals should be maintained to preserve a trail for management and auditors.

Recommendation 10.2

We recommend that all alternative funding agreements be approved as required by Section 59 of the Provincial Finance Act and that the Department of Health retain documentation relating to such approvals.

- 10.33** **Payments** - We tested a sample of 11 AFP/APP contracts to determine whether payments complied with the agreements. Our sample consisted of 8 group contracts and 3 individual contracts, with payments totaling approximately \$3.5 million. Our testing found no errors.
- 10.34** For all agreements we reviewed, there was evidence in the files of a comparison to fee-for-service (where applicable) or fees paid in other jurisdictions. However, for a majority of the agreements we examined, the documentation of this financial analysis and its role in the final agreement required improvement. The financial analysis was not clear and we required subsequent explanations by several staff members to explain procedures performed and linkages to final agreements.
- 10.35** We noted that the file documentation supporting more recent contracts was improved through the inclusion of an “AFP Negotiation Summary” document prepared for each negotiation. The AFP negotiation summary helps to identify procedures employed, but does little to support actual documentation of such analysis. This summary sheet could be improved by adding direct linkages to the background work completed (i.e., an audit trail).

10.36 We noted one occasion where funds started to flow to a physician group without the unanimous opting in of all physicians involved. The explanation we received was that, in some cases, signed members' declarations were not received on a timely basis by the Department of Health. In another situation, not all physicians involved opted into the plan and they were listed as exceptions. This does not concur with the AFP/APP objectives of including all physicians involved and the Department has indicated that it will revisit this on renewal of the specific contract.

10.37 **Deliverables** – Deliverables are outcomes or results to be achieved through the agreement. The role of deliverables is to provide a direction and expectation for the physicians and the Department. Best practices for establishment of deliverables include the following:

- Deliverables should be explicit, easily understood and agreed upon.
- To maintain an appropriate balance between quality and quantity of service, mutually acceptable deliverable targets should be developed and included in formal contracts.
- Deliverables should create a reporting relationship in which the physician is accountable not only for the quantity of services, but also the quality.

10.38 We reviewed eleven agreements which had all been completed prior to the new framework. We found that four contained no deliverables at all, while another contained “baseline” deliverables which consisted of three short sentences. The following is quoted from the Department of Medicine – Critical Care contract.

- “Provision of continuous on-site ICU coverage at both the Halifax Infirmary and Victoria General sites of the QEII.
- Development of a critical care training program at Dalhousie University. The Critical Care Program should be expected to have an approved program in two years. The program would need to be approved by the Royal College.
- Other academic responsibilities as defined by Dalhousie University.”

10.39 The five agreements with few deliverables comprised approximately \$54 million (60% of our sample). The agreements included a section for deliverables. However, the schedules/appendices where deliverables were originally planned to be included are basically blank pages. In those cases where deliverables had been developed, we observed deficiencies.

10.40 **Reporting** – Accountability mechanisms should also be included in all agreements. Whereas deliverables outline specific expectations for each party, accountability mechanisms are the tools used to measure whether deliverables have been met. It is also important for the Department of Health to have a monitoring mechanism in place to ensure that all required reporting is received.

- 10.41** For example, an agreement relating to Fisherman’s Memorial Hospital emergency Department defines a deliverable to be the provision of 24-hour Emergency coverage. The related accountability mechanism is a quarterly report to the Department of Health outlining the actual coverage for that period.
- 10.42** We examined 11 contracts and made the following observations:
- Seven contracts did not have accountability mechanisms in place for performance measurement. In those cases, the Department of Health did not have sufficient information to determine whether services were provided as negotiated.
 - Four contracts included accountability mechanisms. However, they had no provisions or incentives to promote the achievement of deliverables. For example, there were no penalties for failure to reach deliverables or neglecting reporting/accountability requirements.
 - Only one of the eleven contracts reviewed included a requirement for data/reports to satisfy all deliverables outlined in the agreements.
- 10.43** There is a position at the Department of Health with responsibility for monitoring receipt of deliverables under the agreements. However, at the time of our audit, there was little activity in this area because the deliverables were not specified in the existing contracts.

Recommendation 10.3

We recommend that the Department of Health proceed with its plans to implement a new framework for alternative funding arrangements. The agreements should include specific deliverables and accountability provisions for measuring whether deliverables have been achieved.

Individual Beneficiary Registration System

- 10.44** **Background** - The Department of Health is responsible for establishing the policies covering entitlement to MSI benefits. The beneficiary registration process controls access to medical services in the Province through issue of an MSI card which entitles the holder to receive insured services. If this process was not functioning properly, the Province would risk providing access to health services to persons who are not entitled to receive them. Medavie is responsible for administering the registration process for individuals entitled to health services according to DOH policies.
- 10.45** To be eligible for insured health services under the Nova Scotia Health Plan, an individual must be:

- a Canadian citizen or be legally entitled to remain in Canada;
- a permanent resident in Nova Scotia; and
- ordinarily present in Nova Scotia for at least six months in a 12-month period.

- 10.46** **Results of audit** - We reviewed the policies and internal controls related to completeness and accuracy of the beneficiary registration database. We performed audit tests on a sample of registrations and concluded that there was a weakness with respect to expired health card numbers.
- 10.47** We selected 60 new registrations during 2004-05 as sample items from the various classes of beneficiaries in the registration database. Our testing results revealed compliance with the DOH policies and with the internal controls surrounding the registration process leading up to entry in the database. We also used data extraction software to perform analysis of the electronic database including a search for duplicate health card numbers issued to the same individual. We found no errors.
- 10.48** Health cards are valid for a four-year term and are to be renewed. The beneficiary is sent a renewal form which is to be completed and returned. As reported in Chapter 10 of the 2003 Report of the Auditor General, MSI continues to pay claims on expired health cards as directed by the Department of Health. DOH maintains that the majority of the services would have been provided to otherwise eligible residents of the Province who simply neglected to renew their health cards. Using data extraction software, we estimate that payments made on behalf of expired card holders in 2004-05 amounted to approximately \$0.5 million or .2% of the fee-for-service billings. The payment of claims for expired health cards increases the risk of payment for ineligible individuals and reduces control over the beneficiary registration process. We repeat our 2003 recommendation in this area.

Recommendation 10.4 (repeated from 2003)

We recommend that the Department of Health conduct a detailed analysis of the risks and benefits associated with the payment of claims for expired health cards and that appropriate controls and procedures be implemented.

- 10.49** We examined the relationship between the number of registered beneficiaries (957,000) and the population of the Province (936,000). Because the number of beneficiaries is larger than the population by 21,000 or approximately 2%, there is a risk that some of the registered beneficiaries may be ineligible. There are factors which cause the number of beneficiaries to vary from the population such as military and RCMP personnel resident in Nova Scotia not eligible for MSI, registered beneficiaries no longer resident in Nova Scotia, and temporary residents of Nova Scotia who are not eligible for MSI. To increase control over the

beneficiary registration process and the completeness and accuracy of the database, the gap between the number of registered beneficiaries and the population should be monitored and the variance should be explained.

Recommendation 10.5

We recommend that the Department of Health and Medavie monitor the gap between the number of registered beneficiaries and the Province's population and provide an explanation of variances.

Provider Registration System

- 10.50** **Background** - The College of Physicians and Surgeons of Nova Scotia is the professional body responsible for regulating the Province's medical profession in accordance with the Nova Scotia Medical Act and regulations. The College's responsibilities include physician registration and licensing. There were approximately 2,166 physicians in 2004-05 receiving payments under MSI.
- 10.51** Medavie is responsible for maintaining the registration process for providers of insured medical services. Licensed physicians apply to Medavie for registration and are to be provided with specific and unique billing numbers. If this process was not functioning properly, the Province would risk making payments to unlicensed or unregistered providers, or claims for payment could be filed under multiple billing numbers. Medavie maintains a computerized database of registered providers and relevant policies are documented in a manual. DOH is responsible for establishing the policies to be followed in maintaining the provider registration system.
- 10.52** **Results of audit** - We found that DOH policies surrounding the provider registration process were not current. These policies were approved in late 1999 but are not followed. For example, the policy refers to a billing number committee, and specifies its membership, a meeting schedule and the committee reporting schedule. However, this committee no longer exists. Despite the lack of compliance with specific policies, Medavie has established operating procedures which satisfy basic internal control requirements for the issue of billing numbers to licensed physicians

Recommendation 10.6

We recommend that the Department of Health update its provider registration policies and communicate them to Medavie.

- 10.53** We selected a sample of 31 new physician registrations during 2004-05 from the provider registration database and tested the documentation of controls prior to entry in the database. We found that the controls described by Medavie were in

effect. We also used data extraction software to analyze the electronic database including a search for duplicate billing numbers issued to the same physician. We found no errors.

Monitoring Activity

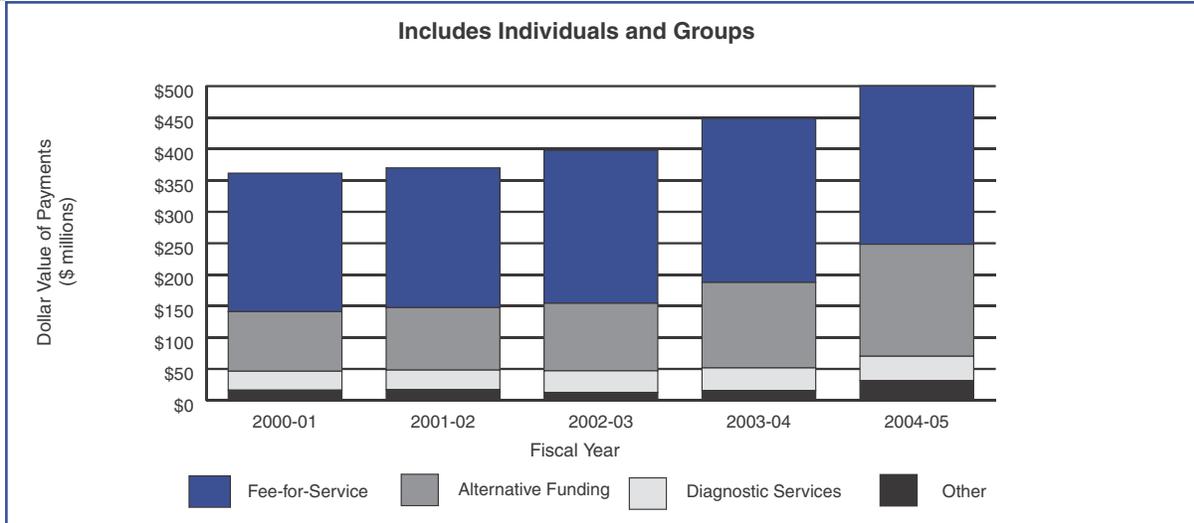
- 10.54** **Background** - DOH is responsible for monitoring physician payments and has contracted Medavie to perform this function. Medavie has a Monitoring and Statistics Division which performs audits of MSI transactions. Various types of audit tools are used to verify claims submitted by physicians such as service verification letters sent to patients, physician profiles, on-site billing audits, and internal billing audits. The Monitoring and Statistics Division prepares annual plans based upon risk assessments, and reports annually to the Department of Health.
- 10.55** **Results of audit** - We reviewed the 2003-04 and 2004-05 audit plans and audit activity reports of the Monitoring and Statistics Division of Medavie. We concluded that Medavie employs appropriate audit planning and risk assessment practices.

CONCLUDING REMARKS

- 10.56** Development of appropriate compensation strategies for physicians is a complex and challenging area. Specialists and general practitioners are involved in a diverse range of activities, both clinical and non-clinical, in many different practice settings. Compensation has a potential impact on what physicians do, how they do it and where they do it. Attractive compensation packages may help to alleviate physician shortages while poor compensation may lead to shortages. There are many stakeholders affected by the physician compensation process and changes cannot be imposed unilaterally; extensive negotiations must precede any changes to agreements.
- 10.57** The Department of Health and Doctors Nova Scotia have been using alternative funding arrangements as a mechanism to achieve their goals for physician compensation. Our 2000 audit of this area and a 2005 consulting report issued by North South Group Inc. identified concerns with the way in which these arrangements had been implemented and the resulting impact on the Department of Health's ability to appropriately manage this area.
- 10.58** Nova Scotia's approach to physician compensation continues to evolve. The Department of Health and Doctors Nova Scotia have made significant efforts to improve alternative funding arrangements and there is recent evidence of progress. A new framework has been approved in principle by the Labour Relations Committee of Executive Council but has not yet been reflected in any signed alternative funding agreements. Progress has been slow and is still in a developmental stage. We encourage the Department to proceed with

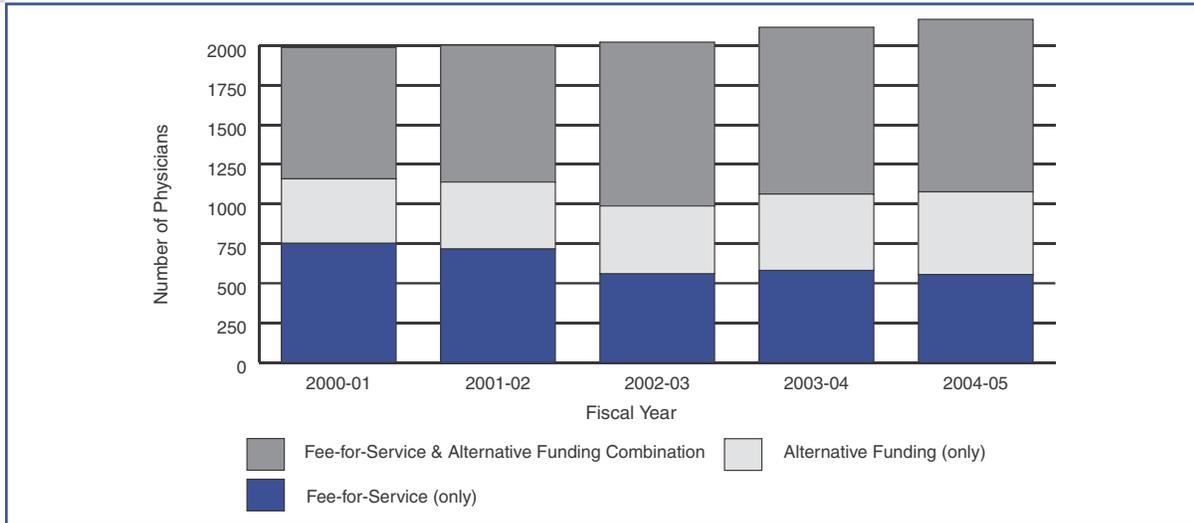
implementation of the new framework in a manner which achieves appropriate accountability for the expenditure and due regard for economy and efficiency.

Payments to Physicians by Type of Payment



Source: Medavie reports to DOH

Physicians by Type of Remuneration



Source: Medavie reports to DOH

Academic Funding Plans/ Alternative Payment Plans Framework Summary of Key Features

Exhibit 10.3

Note: As presented by DOH to Labour Relations Committee of Executive Council in April 2006 and accepted as the general direction for future alternative funding negotiations.

- Represents a “blended” compensation model (i.e. consists of ‘fixed’ and FFS funding)
- Differentiates between clinical and non-clinical funding to allow for clear delineation of respective deliverables
- Contains direct accountability measures for:
 - ‘fixed’ funding (through explicit non-clinical deliverables such as teaching, research output, leadership, on-call, etc.); and,
 - FFS funding all within identified deliverables
- Performance based contract which directly addresses productivity/output decline concerns associated with existing AFP/APP’s (“no work, no pay”)
- Clarifies rules for how physicians are compensated (i.e. depending on physician status and service setting)
- Compensation components permit easy inter- and intra-AFP/APP comparisons
- Compensation package to not exceed average full time provincial fee-for-service experience, unless there is a demonstrated need to address national competitiveness issues.
- Overall Framework ensures equity within and among AFP/APP’s (equal compensation for work of equal value)
- Clear delineation of requirements for funding will provide greater clarity and comparability between various geographic regions. This will reduce the pressures for adjustments based on anecdote.
- Ability to target additional services once contracted services are met.
- Contains inherent flexibility that will fully accommodate changing needs as these are identified
- Aligned with needs of all stakeholders
- Effective full compliance with 41 of 43 DOM Audit Recommendation (2 exceptions relate to IT systems)
- Proposed model and funding levels will result in improved access and therefore better patient outcomes.

DEPARTMENT OF HEALTH'S RESPONSE

We have reviewed the Report and Recommendations on the Payment to Physicians Audit, and would like to provide the following management responses to each of the recommendations.

Recommendation #1

We recommend that the Department of Health revise its policies for physician alternative funding arrangement to reflect current practice.

Department of Health policies are in the process of being revised to ensure their alignment with the new AFP framework. Part of this initiative includes the establishment of a Provincial advisory committee by September 2006, to oversee and guide the development of related policies and procedures in a consistent manner throughout the province. The time-frame for the completion of this aspect of the Committee's mandate will be March 31, 2007.

Recommendation #2

We recommend that all alternative funding agreements be approved as required by Section 59 of the Provincial Finance Act and that the Department of Health retain documentation relating to such approvals.

It is intended that the provisions of Section 59 of the Provincial Finance Act be adhered to.

Recommendation #3

We recommend that the Department of Health proceed with its plans to implement a new framework for alternative funding arrangements. The agreements should include specific deliverables and accountability provisions for measuring whether deliverables have been achieved.

A template master Alternative Funding Agreement has been completed, and at the time of this review, the framework has been accepted in principle by Cabinet.

Recommendation #4

We recommend that the Department of Health conduct a detailed analysis of the risks and benefits associated with the payment of claims for expired health cards and that appropriate controls and procedures be implemented.

The Department of Health will conduct an in-depth analysis associated with the payment of claims for expired health cards. The Department will review the current status of health legislation changes to determine if the Health Services and Insurance Act can be amended in order to re-implement the expiry date requirement. The Department recognizes that the re-implementation of the expiry date check is important in ensuring the integrity of the health card registration database.

Recommendation #5

We recommend that the Department of Health and Medavie monitor the gap between the number of registered beneficiaries and the Province's population and provide an explanation of variances.

The Department of Health will continue to monitor the gap between the number of health cards issued and the population of the province. The Department of Health will review the current variance of approximately 21,000 health cards to determine if these can be explained. As stated in the Auditor General's report when residents move out of province, they do not necessarily contact MSI to notify them, as they believe they have a valid card. Both the Department of Health and Medavie Blue Cross will have to improve the information available to the public to ensure residents are aware of health card requirements. The total of 957,000 could include deceased individuals, residents who have moved out of province, adoptions, NATO personnel etc. The Department of Health will attempt to validate these numbers.

Recommendation #6

We recommend that the Department of Health update its provider registration policies and communicate them to Medavie.

The Department of Health concurs, and will begin to address this issue in the upcoming year.