9.

HEALTH - PHYSICIAN ALTERNATIVE FUNDING INITIATIVES

BACKGROUND

9.1 Physicians in Nova Scotia have traditionally been paid on a fee-for-service basis under the Medical Services Insurance (MSI) plan of the Province. Under this system, physicians submit a claim for each medical service provided. The MSI system pays the doctor for the service based on its value as set out in the 1997 contract between the Department of Health and the Medical Society of Nova Scotia (MSNS).

9.2 However the fee-for-service system has been criticized for certain unintended negative side effects to physicians and the health care system. Both the 1989 *Report of the Nova Scotia Royal Commission on Health Care* and a 1997 Department study entitled *Good Medicine: Securing Doctors Services In Nova Scotia* summarize problems inherent in the traditional fee-for-service payment system including:

- physicians' earnings are tied to the number of patients seen creating a potential for over-servicing;
- medical service volumes are open-ended which can lead to escalating costs;
- lack of responsiveness to the different practice settings of physicians;
- lack of incentives to engage in health promotion and disease prevention;
- failure to provide incentives to promote efficiency in the delivery of physician services by including other health care professionals in physicians' practices;
- lack of stability and predictability in physician funding; and
- failure to provide adequate patient access to family doctors and specialists in rural areas and inadequate staffing of emergency rooms.

9.3 Both of these studies recommended alternative physician funding in addition to the traditional fee-for-service payment system.

9.4 Although some variations in the traditional fee-for-service payment system have been in place for many years, there has been a significant increase in the number and variety of Alternative Funding Initiatives (AFI) in the last seven years. In 1997, the contract with MSNS included provisions for special arrangements for physician remuneration and alternate emergency room and rural stabilization funding. These initiatives are intended to address some of the problems associated with the traditional fee-for-service payment system.

9.5 The Department of Health's payments for AFI's were $85.3 million in 1999-2000. AFI expenditures were $11.5 for the 1992-93 fiscal year. A summary of payments to physicians under AFI's is provided in Exhibit 9.1.

9.6 Alternative Funding Initiative contracts fall into three general categories:

- *Medical Specialists* - These AFI's consist of contracts with physician groups or individual medical specialists. These contracts tend to be initiated by the physician or physician group to address specific problems associated with the fee-for-service system unique to the group or individual. There are currently 10 group and 21 individual AFI contracts with medical specialists with expenditures of approximately $52 million during 1999-2000.

- *Emergency Room* - There are two programs associated with emergency room (ER) funding. The first program provides hourly remuneration to physicians to ensure 24-hour medical coverage for Level 3 and 4 regional and tertiary ER's. The second program is referred to as Rural Stabilization and involves providing guaranteed hourly funding to on-call physicians for emergency room coverage. The program also provides lump-sum payments to general practitioners (GP's) who practice in communities more than 45 kilometers from an ER. Annual funding for ER AFI's was approximately $22 million for the 1999-2000 fiscal year.

- *Rural General Practitioners* - This program is intended to attract physicians to rural communities which have difficulty recruiting and retaining family doctors. Physicians are paid a base guarantee which replaces the traditional fee-for-service remuneration. This program cost the Department approximately $11 million in 1999-2000.

9.7 For each AFI, a contract is negotiated between the Department, the physician or physician group and the Medical Society of Nova Scotia. MSNS acts as the official bargaining agent for physicians. For some medical specialist contracts, there may be other parties to the contract including the Dalhousie Medical School and specific acute care facilities.

9.8 The Department's Director of Insured Programs and Manager of Program Funding have direct responsibility for AFI's. The day-to-day administration of contract payments is handled by Maritime Medical Care Inc. (MMC). MMC's duties include paying physician contracts biweekly, maintaining a database of medical service information provided by physicians and audit and verification responsibilities.

9.9 This audit was conducted in accordance with Section 8 of the Auditor General Act.

RESULTS IN BRIEF

9.10 The following are the principal observations from our review.

- The Department of Health and the Medical Society of Nova Scotia have established a Principles document for negotiating AFI contracts. This is an important first step in ensuring consistency of alternative funding initiatives with the objectives and priorities of the Department.

- A principle of the AFI contract system is that "*payments should typically draw no more resources from the Medical Services Insurance (MSI) budget/allocation than was historically drawn by fee for service....*" The evidence we examined indicates that, on average, AFI contracts cost more than historical fee-for-service remuneration.

- When investigating an AFI proposal, the Department does not prepare a summary document which clearly sets out specific outcomes. In addition, the estimated cost of the AFI proposal is not compared to a fee-for-service alternative which takes into account projected future utilization. Such a document, which clearly articulates relative AFI costs and benefits, is important to ensure accountability for program results. We recommended that such a document be prepared.

- The Department's authorization process for AFI contracts appears to be operating appropriately.

- We found weaknesses in the control system for AFI payments administered by Maritime Medical Care Inc. to reduce the risk of inaccurate data input and duplicate payments. We have recommended increased monitoring to reduce the risk of data input errors and overpayments.

- Evaluation of the effectiveness of AFI's depends on data collection through the shadow billing system. This system also supports billings to other provinces for services provided to non-Nova Scotia residents. We found that controls to ensure the completeness of shadow billing submissions are not adequate, particularly for medical specialists. Monitoring of the completeness of shadow billing information is now being performed on an ad hoc and infrequent basis. We note that the Department and MMC are developing a quarterly reporting system which should help to address this deficiency.

- Both the 1997 contract with the Medical Society of Nova Scotia and the individual AFI agreements call for contract evaluations. The Department has established an Evaluation Steering Committee with the Medical Society of Nova Scotia and Terms of Reference to guide the evaluation process. We have recommended more frequent evaluations and changes to the scope of evaluations.

- Individual AFI contracts permit the Department to decrease payments after 90 days if actual service levels are less than the contract payments. However, this provision is very difficult to implement because of the manner in which the contracts are structured. We have recommended that these provisions be strengthened and enforced.

AUDIT SCOPE

9.11 The objectives of this assignment were to:

- assess systems and practices which provide for the administration of Alternative Funding Initiatives with due regard for economy and efficiency;

- assess the planning, authorization, management, reporting and accountability framework in place at the Department of Health over Alternative Funding Initiatives;

- document and assess the systems and controls over payments to physicians under the various alternative funding contracts including controls to ensure that physician obligations and accountabilities are met; and

- test a sample of physician payments under alternative funding initiatives to ensure that key controls identified are working as documented, payments are accurate,

authorized, complete and agree to contract details, and that physician obligations are being complied with.

9.12 Audit criteria developed for this assignment were discussed with management of the Insured Programs Branch of the Department at the outset of the audit and are presented in Exhibit 9.2. Our audit approach included interviews with staff of the Department of Health's Insured Programs Branch and Maritime Medical Care Inc., detailed examination of contracts, files, reports and other documentation and detailed testing of a sample of 40 contract payments.

9.13 Pursuant to the 1997 contract with MSNS, the Department also provides funding to physicians for health and malpractice insurance and to offset the cost of sales taxes. Some physicians also receive stipends and salary supplements from acute care facilities separate from the AFI process. These additional payments are not included in the scope of this audit.

PRINCIPAL FINDINGS

Developing New Alternative Funding Contracts

9.14 *Principles for negotiating AFI contracts* - General requirements for establishing AFI contracts are provided in the March 1997 contract with the Medical Society of Nova Scotia. In addition, the Department of Health and MSNS have established a Principles document for negotiating AFI contracts. This is an important first step in ensuring consistency of AFI initiatives with the priorities of the Department. This document sets out a framework within which all Alternative Funding contracts are developed. The Principles document is applicable mainly to AFI contracts with medical specialists but has general applicability for all AFI contracts. The objectives and conditions for AFI contracts, as set out in the Principles document, are provided in Exhibit 9.3.

9.15 The Principles document requires physicians to submit AFI proposals to MSNS. Proposals are then presented to the Department of Health for consideration. The Department analyses historical fee-for-service billings over the last three years to determine the maximum funding levels for the AFI. The Department then researches the number of full-time physicians (FTE's) that should provide service under the AFI contract. The Department does not have a formal physician resource plan upon which to base this analysis. Department management informed us that a physician resource plan is now being developed. The results of these analyses serve as a basis for a negotiated agreement with the physician group and the Medical Society.

9.16 One condition in the Principles document is *"payments should typically draw no more resources from the Medical Services Insurance (MSI) budget/allocation than was historically drawn by fee for service...."* In practice, the Department considers the past three years of fee-for-service billings and selects the best year for each physician in the AFI group in calculating the base funding level under an AFI agreement. The implication from this practice is that, on average, AFI's will cost more than historical fee-for-service.

9.17 Department files contain detailed cost and resource analysis to support an AFI proposal. We note that a summary document is not prepared which clearly defines the specific problems or conditions that a proposed AFI is intended to address and the anticipated clinical outcomes. The estimated cost of an AFI proposal is compared to historical fee-for-service expenditures adjusted for rate increases. However the comparison does not take into account fee-for-service utilization projections based on historical trends. Clear articulation of relative costs and benefits is important to ensure accountability for program results. We recommended that such a document be prepared.

9.18 We also note that acute care facilities are permitted to provide financial incentives to attract medical specialists without informing the Alternative Payments Section of the Department. This practice carries the risk that all sources of funding to a specialist group are not being fully considered when new AFI's are negotiated.

Authorization of Alternative Funding Contracts

9.19 We found the authorization process for AFI contracts to be appropriate. AFI contracts are approved by Department senior management prior to being signed by the Minister of Health. Contract wording is reviewed by legal staff of the Department prior to signing.

Payment Systems for Alternative Funding Contracts

9.20 *Background* - The processing of AFI payments is the responsibility of the Director of MSI Programs at Maritime Medical Care Inc. (MMC). Data entry of payment information to the MSI system is performed by the Alternate Funding Coordinator.

9.21 AFI payments are made biweekly based on the contract details recorded in the MSI system. Contract details for new AFI agreements or changes to existing contracts are input to the system via an authorization letter from the Director of Insured Programs of the Department. All additions and changes require the Coordinator to manually recalculate and enter the biweekly payment to the MSI system.

9.22 *Controls over data input* - We tested 40 biweekly AFI payments during the 1999-2000 fiscal year and noted one payment entered incorrectly to the MSI system. MMC management estimated that this error resulted in an overpayment of approximately $154,000 to a group of medical specialists and arrangements are now being made to recover this amount. The error appears to be the result of a weakness in the data entry procedures where contract interpretation, payment calculations and data entry are not verified by supervisory staff at MMC. We have recommended that MMC strengthen controls over the input of biweekly payments to the MSI system. Further the biweekly payment amounts for the remaining contracts on the system should be reviewed for accuracy.

9.23 *Controls over duplicate claims* - Under the fee-for-service system, physicians submit Service Encounter Claims to MMC which detail the medical services provided by the physician. The MSI system will only accept claims that have a valid billing number and a valid business arrangement number. Physicians have only one billing number but may have multiple business arrangements depending on the nature and locations of the doctor's practice. The MSI system automatically checks for duplicate Service Encounter Claims under the fee-for-service system.

9.24 When a physician enters an AFI arrangement, the fee-for-service business arrangement number is suspended to prevent duplicate billings under the two systems. However, a risk of duplicate billing remains because a fee-for-service claim could still be submitted under one of the physician's remaining business arrangement numbers.

9.25 To illustrate this concern, the Monitoring and Statistics Section of MMC conducted an audit to detect fee-for-service payments under the Emergency Room Rural Stabilization Program. Under this Program, physicians are not permitted to submit fee-for-service claims during certain times covered by the Program. This audit revealed $83,513 in fee-for-service billings which have been recovered from the physicians.

9.26 We are concerned about the risk of overpayment, particularly for medical specialists under AFI contracts who may also be permitted, in certain circumstances, to submit fee-for-service claims.

We have recommended that the Department re-examine the risk of overpayment and implement controls to detect duplicate payments if appropriate.

9.27 *Responsibilities for contract monitoring* - A 1992 contract between MMC and the Province outlines, in very general terms, the responsibilities of MMC for the payment, audit, and assessment of payments to physicians. Since that time, there has been a significant increase in the types and dollar value of AFI contracts and payments now total $85.3 million annually.

9.28 Section 15 of the 1992 MMC contract allows the Department to issue policy and procedural directions to MMC to clarify administrative, audit and investigative responsibilities. No policy and procedural directions have been issued by the Department for AFI contract administration. We found that responsibilities for contract monitoring, specifically for the follow-up and investigation of shadow billing information described more fully below, were not well defined between the Department and MMC staff. We have recommended that the Department clarify roles and responsibilities of Department and MMC staff for AFI contract monitoring.

Data Collection - Shadow Billing

9.29 *Overview* - Under the fee-for-service system, physicians submit Service Encounter Claims which serve several purposes. Claims trigger payments to the physician, provide evidence that a medical service has been received, serve as a basis for billing medical services to other provinces under reciprocal billing agreements and provide valuable data for health care planning.

9.30 Under AFI contracts, physicians are paid automatically on a biweekly basis regardless of the medical services actually performed. Physicians under AFI contracts are therefore required to submit service encounter information. Service encounter information submitted under an AFI contract does not trigger a payment to the physician and for this reason is referred to as a shadow billing. The complete and accurate submission of shadow billing information is important for the same reasons as Service Encounter Claims cited above.

9.31 To ensure complete and accurate submission of shadow billing information, the value of shadow billing data is periodically compared to total payments under the AFI contract. AFI contract funding was originally designed so as not to exceed the funding historically incurred under the fee-for-service billing system. To ensure that fee-for-services costs are not exceeded, AFI contracts with medical specialty groups contain a clause where payments can be reduced if shadow billing information indicates that medical services provided are less than contract payment amounts. Therefore, although some variation between AFI payments and shadow billing information can be expected, the two figures should be reasonably close.

9.32 *Medical Specialist Group contracts* - We found controls to ensure completeness of shadow billing submissions are not adequate. Monitoring of the completeness of shadow billing information is being performed on an ad hoc and infrequent basis.

9.33 We examined a report prepared by MMC which compared the value of shadow billings for medical specialty group contracts to AFI contract amounts paid during the 1999-2000 fiscal year. The report indicates that AFI contract amounts paid exceeded the value of shadow billings by $9.4 million or 24%. For individual AFI contracts, the excess of AFI payments over shadow billing values ranged from 9% to 89%.

9.34 Department management informed us that the excess of contract payments over the value of shadow billings may be due to several factors including the following.

- Physicians may be spending more time with patients in an effort to improve the quality of patient care, resulting in fewer patient visits and lower shadow billings.
- Medical specialty AFI's allow for additional physicians to reduce patient load in areas considered overworked under the previous fee-for-service system.
- Shadow billing information may not be reported in a complete manner by physicians.

9.35 We are particularly concerned that shadow billing information reported by physicians may not be complete. This may translate into lost reciprocal billing recoveries for the Department. Shadow billing is the only source of data for reciprocal billing to other provinces for AFI contracts. Department management informed us that 5% to 8% of patients admitted to acute care facilities are residents of other provinces. Therefore 5% to 8% of the above $9.4 million difference may represent lost reciprocal billing recoveries.

9.36 We recommended that the Department review shadow billings for medical specialty groups on a regular basis and take action in cases where shadow billings by physicians appear incomplete. This review process should be supported by appropriate documentation. We acknowledge that the Department and MMC are currently developing a quarterly reporting system which should facilitate this process.

9.37 *Emergency Room programs* - Department management review shadow billing information for Level 3 Emergency Room sites annually. Cases where the value of shadow billings is significantly lower than the amounts paid are investigated.

9.38 We examined a report which compared the value of shadow billings for Level 3 ER facilities to AFI contract amounts paid during the 1999-2000 fiscal year. Contract payments exceeded the value of shadow billings for this period by $4.4 million or 34%. Department management explained that this difference is likely attributable to a policy decision which requires all Level 3 emergency rooms to have at least one physician on site at all times. For smaller facilities, very few patients may be seen in an 8-hour shift and therefore contract payments will exceed the value of shadow billings.

9.39 When additional Level 3 emergency room funding was established, pursuant to the 1997 contract with MSNS, the Department estimated 24-hour ER service would cost approximately 20% more than the historical fee-for-service system. The above comparison indicates that the actual cost of 24-hour ER service in Level 3 facilities may be as much as 34% more than that paid under the fee-for-service system.

9.40 Department management acknowledges that part of the 34% difference may be due to incomplete shadow billing submissions. As discussed above, a failure by physicians or facilities to submit shadow billing information can result in a loss of reciprocal billing recoveries and incomplete Provincial health data. We recommended the Department investigate more rigorously shadow billing information for Level 3 ER contracts where submissions appear incomplete. This review process should be supported by appropriate documentation.

9.41 *Rural General Practitioner contracts* - Shadow billings for these physicians are reviewed annually by Department management. Department staff visit these physicians annually and shadow billing remittances are discussed where necessary although visits are not always documented. Overall the verification of shadow billing information for physicians with rural incentive contracts appears reasonable.

Evaluation of Alternative Funding Contracts

9.42 The 1997 MSNS contract requires rigorous evaluation of new AFI initiatives. The requirement for evaluation extends only to AFI contracts with medical specialists and rural practitioners. There is no specific requirement in the MSNS contract for evaluations of Emergency Room AFI's.

9.43 The Department has established an Evaluation Steering Committee comprised of staff from the Department, MMC and MSNS. The Steering Committee developed Evaluation Terms of Reference which set out evaluation objectives in three general areas:

- contract compliance and the financial implications of AFI contracts;
- patient access to physicians and changes in service delivery methods and patterns; and
- stakeholder satisfaction with the AFI including physicians, patients, health care facilities and the Department.

9.44 The individual AFI contracts with medical specialists also call for evaluation of clinical outcomes including average length of stay, readmission rates, wait times and other criteria. An assessment of clinical outcomes is a requirement notably absent from the Evaluation Terms of Reference.

9.45 We recognize that the Department's motivation for entering into AFI contracts is often to encourage new and innovative medical approaches and to encourage an increase in health promotion and disease prevention activities by physicians. Department staff inform us that new activities, which AFI contracts are designed to encourage, are often not captured by the MSI information system. The lack of information on the occurrence of new activities leads to difficulty in evaluating AFI contracts.

9.46 The timing and frequency of evaluations is not defined in either the Terms of Reference or the contracts. The Department has not developed a schedule for the completion of contract evaluations. At the time of our audit, there were 37 medical specialist and 46 rural practitioner contracts that were one to seven years old with annual expenditures of approximately $45 million. Of this population, two medical specialist contracts, with annual expenditures of approximately $20 million, had been evaluated.

9.47 Both evaluations were conducted by staff of the Department. One of the evaluation team members is from the Evaluation Section of the Department. The scope of the two evaluations was confined to selected Evaluation Terms of Reference objectives and consisted of various analyses of shadow billing data. There was no evaluation of changes in service delivery methods or stakeholder satisfaction. There was also no evaluation of clinical outcomes as called for in the AFI contracts.

9.48 A noteworthy finding from these evaluations, based on the shadow billing information, was that the value of medical services delivered under the AFI contracts was less than the dollar value of the contract payments. This is consistent with our audit findings discussed above.

9.49 We understand that Department management is now studying the evaluation findings to identify issues for discussion during the next round of contract negotiations with the Medical Society of Nova Scotia.

9.50 The individual AFI contracts permit the Department to decrease payments after 90 days if actual service levels delivered are less than the contract payments. However, this provision is very difficult to implement because of the manner in which the contracts are structured and related reporting requirements. We have recommended that these provisions be strengthened and enforced.

9.51 Although AFI contracts require clinical outcome evaluations, the data requirements for this type of evaluation have not been defined. Unless data requirements are defined and appropriate data collection processes established, the evaluation of medical outcomes may not be possible.

CONCLUDING REMARKS

9.52 Alternative funding initiatives have been advocated for many years as a means of improving the economy, efficiency, effectiveness and responsiveness of medical services provided by physicians. The Department has responded by entering into a variety of AFI programs for medical specialists, emergency room physicians and rural general practitioners. Expenditures on AFI's have increased almost eight-fold in the last seven years. The Department has negotiated written principles with the Medical Society of Nova Scotia as a framework for developing AFI's.

9.53 While AFI's may have potential benefit to the health care system, our audit indicates that conditions giving rise to specific proposed AFI's and the outcomes expected from AFI's generally are not well articulated. This makes evaluation difficult for both specific AFI's and AFI programs in general.

9.54 Our objectives for this audit of alternative funding initiatives for physicians included assessment of the Department's systems and practices to provide for due regard for economy and efficiency and compliance with contracts. We found deficiencies in the systems providing for due regard for economy and efficiency, including:

- need for improvement in the analysis preceding the decision to enter into an alternative funding initiative;
- incomplete shadow billing data; and
- infrequent evaluation of outcomes.

9.55 We also found weaknesses in certain controls which provide for compliance with contracts.

9.56 The Department has created an Evaluation Steering Committee and established Evaluation Terms of Reference. However, only two AFI contracts have been formally evaluated and there does not appear to be a timetable for completing evaluations for the remaining contracts. There are no plans to evaluate AFI programs more broadly, including programs such as emergency room coverage and rural general practitioners. Clinical medical outcomes and stakeholder satisfaction are two important areas which have not been formally evaluated.

9.57 Evaluation of the outcomes of alternative funding arrangements is extremely important to the future of health care in Nova Scotia. Without such information, decision makers lack the evidence to support sound decision-making including whether such arrangements have been successful and whether they should be extended to other physician groups.

Exhibit 9.1

FINANCIAL SUMMARY
SUMMARY OF ALTERNATIVE FUNDING INITIATIVES

Initiative	**Actual 1999-2000**	**Forecast 2000-2001**
Medical Specialty Groups	$52,597,125	$60,464,937
Emergency Rooms	22,033,328	22,666,108
Rural Incentive & Other	10,670,013	10,592,892
Total	$85,300,466	$93,723,937

Exhibit 9.2

AUDIT CRITERIA

- Department objectives, expected accomplishments and constraints should be explicit, understood and agreed upon.

- The Department should have a well defined planning, authorization, reporting and accountability structure in place for AFI's that demonstrates due regard for economy and efficiency including:

  - clear roles and responsibilities;
  - balanced expectations and capacities;
  - cost/benefit comparisons of alternatives;
  - adequate reporting mechanisms;
  - reasonable review and adjustment; and
  - credible reporting.

- Roles and responsibilities of all parties to the accountability relationship (Department, MMC and physicians) should be well understood and agreed upon.

- Credible and timely operational and financial information which demonstrates performance achieved should be reported and reviewed and necessary corrections made to the program.

- Financial transactions and shadow billing information should be documented and retained.

- Contractual arrangements should be documented and approved in accordance with a prescribed protocol and include key terms and conditions including:

  - services to be provided;
  - qualifications of service providers;
  - accountabilities of the service providers;
  - scheduling commitment and length of contract;
  - description of physical facilities and/or equipment to provide the service;
  - reporting relationships;
  - quality improvement expectations;
  - any legislated or regulatory standards that must be adhered to;
  - financial arrangements;
  - liability insurance; and
  - license and/or registration status of the service.

- There should be adequate controls (manual or automated) to ensure that:

  - new contracts with physicians or physician groups are recorded on the payment system in a complete, accurate and authorized manner;
  - payments are accurate, timely and in accordance with contract requirements;
  - contract changes are authorized and documented;
  - services paid for, pursuant to alternate funding contracts, have been received;
  - assets are safeguarded against fraud and loss; and
  - errors are prevented from entering the system and corrected once identified.

- Significant controls within the payment and shadow billing system should be functioning as documented.

Exhibit 9.3

DEPARTMENT OF HEALTH AND MEDICAL SOCIETY OF NOVA SCOTIA
PRINCIPLES FOR NEGOTIATING
ALTERNATIVE FUNDING CONTRACTS
DECEMBER 1997

Objectives:

1. To provide a clinical service to meet the needs of patients.

2. To provide quality medical care.

3. To define scope of physician services to be provided which may include clinical service, teaching, research and administration.

4. To provide funding for services apportioned to the appropriate payers. (Clinical service will be funded by DOH. Academic activities will be funded by Dalhousie University. Research activities will be funded by Dalhousie University and other research grants. Administrative activities will be funded by the health care facility.)

5. To provide fair, reasonable, stable and sustainable funding for physician services.

6. To define the physician resources required to provide the scope of service.

7. To allow flexibility in the delivery of physician services.

8. To establish performance guarantees and define the minimum level of service below which penalties would apply.

Conditions:

1. Alternative funding arrangements may only be implemented with the agreement of the MSNS in cooperation with those physicians affected.

2. Any new alternative funding contracts will be treated as a pilot project for a minimum of one year. Contracts may be signed for a maximum period ending March 31, 2001 (the end date of the 1997 Medical Agreement).

3. In alternative funding arrangements, all members of the group must agree to join the alternative funding proposal. (Active billing numbers will be retired for the duration of the alternative funding contract)

4. The alternative funding contract will define the parties to each alternative funding agreement and the roles and responsibilities of each. Organizations requesting activities of physicians will typically fund these activities as follows:

Clinical Service -	Department of Health
Academic Activities -	Dalhousie University
Research Activities -	Dalhousie University and Other Research Grants
Administrative Activities -	Health Care Facility

5. The alternative funding contract payment levels to physicians will be based on agreed upon manpower levels. Payments should typically draw no more resources from the Medical Services Insurance (MSI) budget/allocation than was historically drawn by fee for service (FFS) billings over the previous one to five fiscal years of funding.

6. Any funding increases provided by the DOH during the term of the contract will be based on changes to the Medical Service Unit (MSU) as detailed in the 1997 Medical Agreement.

7. On an annual basis, the group practice plan or equivalent will provide to the applicable payers a written report detailing the actual distribution of funds to individual physicians within the group.

8. It is important for the DOH to obtain accurate and timely patient services information from all service providers. The claims information submitted to MSI is utilized in a number of ways including:

   - As a research tool, the information is necessary for the determination of population based or diseased-based health care costs. The information assists in developing long term health delivery plans.

   - Patients often contact Maritime Medical Care (MMC) with requests for information on certain services from their medical history. Similarly, third-party requests are received from lawyers, insurance companies, etc. to substantiate service encounters and verify types of services and specific diagnoses.

   Physicians in alternative funding arrangements must report information on services provided directly to MSI through shadow billing or an acceptable alternative method throughout the period of the alternative funding contract. Shadow billing is defined as reporting by physicians in an alternative funding arrangement of insured service encounter information to MSI in the format prescribed by DOH.

9. Evaluation of the alternative funding contract will be performed. Physicians agree to participate in time studies as part of the evaluation protocol.