EMS Funding Issues Aug 2009

Emergency Medical Services (EMS)

Funding Issues Summary

Provincial Funding

The EMS program is stated by the province to be funded at 50% provincial - 50% municipal. However, for several years' provincial contributions did not keep pace with the increase in program costs leaving the municipal governments with an ever increasing share of costs. Finally, in February 2006 the Premier committed to increase funding to ensure that 50-50 funding would be reached by 2008. This commitment was honored and over the ensuing years the sharing of costs has improved and is now close to the 50-50 split. However, it does not reach this goal because the base for determining the 50% provincial share is the prior years approved costs not the current year actual costs.

Between January 1 1998 and December 31 2000 a portion of ambulance costs were assigned by the Ministry of Health directly to individual municipalities. Effective January 1, 2001, ambulance costs began to be billed by the designated Delivery Agents directly to their member municipalities. Since that date municipalities within each DDA jurisdiction were now required to fund all land ambulance in excess of the arbitrarily established provincial grant. Local cost distribution is in accordance with local apportionment models.

The municipal share for ambulance services is determined using the following formula.

Gross costs

Less the assigned share for the Territories Without Municipal Organization (TWOMO)

Less First Nations per capita funding

= Balance to be funded at 50/50

It should be stated that the MOHLTC does not refer to it's contribution to EMS costs as a cost share but refers to it correctly as a grant. There is in fact no legislated commitment to fund 50% of actual costs. The provincial grant may or may not lead to 50% costs sharing in any given year.

Designated Delivery Agents (DDA)

In the South, the Designated Delivery Agent is normally the County or Regional government. In the North, the DDA is normally the District Social Services Administration Board (DSSAB). The three exceptions in the North are the Greater City of Sudbury, the Town of Parry Sound and the City of Thunder Bay. These entities assumed the DDA responsibilities rather than the local DSSAB. There are 49 DDAs in the province.

Wage Costs

EMS costs are primarily driven by wage and benefits costs which represent 81.14% of the total budget. These costs rose significantly following the transfer of the EMS program in 2001. The primary reason was the shortage of paramedics created when the province introduced new educational requirements at the point of program transfer. The move to increased paramedic educational requirements led to a staffing shortage which in turn drove up competition for staff and increased compensation. In the last few years, this trend has modified as the number of paramedic graduates entering the field has increased significantly.

In addition, the development of response time standards at the time of the program transfer and some years of frozen growth in the number of paramedics prior to the transfer led to the need for service improvements. These coverage and service changes lead to an overall increased demand for staff. This trend is also moderating as the impact of the transfer issues diminish.

The most recent trend is an increase in training and supervisory costs as MOHLTC seeks to upgrade the care provided. The provincial regulatory regime requires increased demand for training

and quality control at the local level. These are leading to improved patient outcomes.

Equipment Costs

The next most expensive cost area is vehicle replacement and medical supplies which together represent 10.17% of annual costs. Ambulances are on a set renewal basis driven by age of the vehicle and mileage. That standard is greater than 275,000 Kilometers or greater than 84 months in service (7 years).

Medical supplies are replaced based on usage and specified time limits for medical efficacy.

These two cost areas are not consistent from year to year. In order to provide some consistently in the demand for funding revolving capital funds have been created. Set amounts are set aside each year in to these funds and then vehicles or supplies are purchased from the funds as required. Without these revolving capital funds EMS expenditures would swing dramatically year to year. The amount to be set aside is reviewed each year to ensure it remains adequate

Cross Border Billing

Service charges may occur between Designated Delivery Agents (DDA) if land ambulance services are performed by one DDA in the jurisdiction of another DDA. Prior to ambulance services been downloaded, the issue of cross-border billing did not exist. There were costs associated with each individual ambulance service and each service was separately funded. However, up to December 31, 1997 the entire budget monies came from the provincial government so flowing funding across jurisdictions was not necessary.

Since that date, the cost of providing local resources to other jurisdictions has become a significant issue.
For example, if this Board's EMS ambulance was to enter the Algoma District to respond to a call the question as to who should pay for the call becomes an issue. Then understanding is that

when the Manitoulin–Sudbury EMS ambulance completes a call in Spanish then the Algoma DSSAB should pay. If the City of Greater Sudbury EMS service responds to a multi-vehicle accident in Estaire then this Board should pay for that response.

Concurrent with the Local Services Realignment, the provincial government set out a regulation to address the matter of cross border billing and provided for a legislated fall back system for allocating costs. However, the MOHLTC went one step further and prior to 2006 actually reduced or added to EMS budgets based on assumptions about cross border billings. This assumption was a great detriment to this Board as the local EMS budget was reduced on the assumption of significant payments from the City of Greater Sudbury service and other DDAs. This lead to the launching of law suits to recover monies between DDAs when these funds were not forthcoming.

The legislation provided for the development of a mutually agreeable formula for cross border billing of ambulance services. If the parties could not agree on a formula for cost sharing, then the default option in the legislation would fall into place. The default option meant that each entity would calculate their cost per call (total cost of operations/number of calls per year). Each DDA declared the number of pickups in the others area and the DDA with the most calls done in the other's area could to send the bill for only the excess number of calls completed multiplied by their local cost per call.

The legislation has now been revised and there is no legislated backup related to the cross border agreements. More importantly, MOHLTC no longer adjusts budgets based on assumed revenues from cross border billing.

In addition, there has been a significant province-wide reinterpretation of what constitutes a cross border billable call. This refined definition of what contstitues a cross border call has a significant impact on several DDAs. Previously, the interpretation was that the point of patient pick-up drove the determination of who was financially responsible for the call. That meant that a patient drop off at a hospital in another jurisdiction and then returned to their own jurisdiction constituted a cross border call. Presently, the

interpretation is that the repatriation of patients from one jurisdiction to their jurisdiction of residence does not constitute a billable call.

Between 2007 and 2009 this Board was able to reach agreements with the surrounding six DDAs. Some of the agreements were based on the removal of repatriation as a billable cross border call. Several of the agreements allowed for a cash settlement and a period of no billings. This was due to problems confirming exact number of calls as a result of obvious errors with the province wide EMS call database.

All existing cross border agreements allow for future billings based on actual billable calls and the new definition of what a billable call is. However, the total number of cross border calls is decreasing significantly as each service approaches their full staff complements. When a service has a full complement, the Central Ambulance Communications Centre (CACC) is much less likely to be calling on an adjacent service to step in. The impact of cross border calls and the resulting cross border revenue are declining dramatically.

First Nations Funding

The initial EMS budget template put forward by the MOHLTC had arbitrary amounts assigned for the net financial impact of providing services to First Nations for each DDA jurisdiction. No information was ever supplied to justify the original funding template calculations. The First Nations funding became a crisis in 2006 due to the Ministry's insistence that the total amount payable to DSSABs should be significantly reduced in the future based on actual call volumes. However, through lengthy negotiations, it was agreed that the Ministry would fund First Nations services based on a per capita basis.

The First Nations per capita funding is based on the most recently available band population numbers and in any case in which the band population number is not available the assumption is that the population is 40. The DDA's most recent year's actual per capita costs which are available at the time of calculation is used to set the per capita amount. The per capita amount flowed to each DDA

will be the per capita amount for that DDA paid for all those reserves to which they are actually providing the service. The issue of how to flow funds when a DDA serves First Nations external to its jurisdiction and the issue of how to flow funds when one DDA provides services to an adjacent DDA requires that each DDA clearly advise the MOHLTC of service delivery patterns so that the Ministry can identify any areas of dispute before flowing funds to the correct DDA.

Wikwemikong EMS

The Wikwemikong EMS Station is operated by the Manitoulin-Sudbury DSSAB on behalf of the Province of Ontario. This was an agreement reached between the Ministry of Health and Long Term Care in March 2004.

The DSSAB operates this station at 100% cost recoverable monies. The ambulance vehicles and the fixed medical equipment are owned by the Province of Ontario and only replaced once approved by the province.

The DSSAB and Ministry of Health reconcile the operating costs at the end of each fiscal year.