AOM Briefing Note: Barriers in integrating services for uninsured funding & newborn OHIP

Background

Uninsured pregnant people in Ontario face significant barriers accessing midwifery care, which impacts both the pregnant person and their newborn, as well as the broader healthcare system. Despite the availability of uninsured midwifery funding to address gaps in care for Ontario residents without health insurance since 2014, the current lack of clarity around eligibility criteria to access the uninsured midwifery funding, lack of mechanisms for newer midwifery models to access uninsured funding, and inconsistencies across TPA operational practices for funding uninsured clients are hindering effective service integration as outlined below. Additionally, discrepancies in the issuance of OHIP for newborns by hospitals and Service Ontario staff persist, despite newborns' eligibility for OHIP. These issues result in preventable health complications and increasing costs for the healthcare system. Immediate action is needed to resolve these barriers and ensure uninsured pregnant individuals can access essential healthcare services and eligible newborns receive OHIP.

AOM-OMP Agreements

In a meeting on March 12, 2014, the OMP and AOM agreed to a process through which midwives can access the uninsured funding, based on the following principles (see Appendix 1):

- Funding should follow the medical needs of the client and should be seamless at point of care
- No service providers should be concerned that they will not get paid
- Payment should be equal to the amount the service provider would earn with an OHIP insured client, and should be issued in a timely fashion
- There should be checks and balances in place to ensure accountability and valid billing
- The system should not be administratively onerous on health providers

This program was based on an average cost of $1,953 per client. If a client is highly complex and requires services that exceed $1,953, the MPG will notify its TPA as soon as possible. TPAs will assign additional funds on a case-by-case basis (see Appendix 2).

These commitments to supporting access to care for uninsured midwifery clients have helped ensure a healthy start for generations of Ontarians. They underscore the vital role midwives play in leading perinatal and reproductive care for uninsured families, and highlight the benefits of enhancing equitable access to essential healthcare services on community well-being.

Key Issues:

1. **Transfer Payment Agency (TPA) Funding Discrepancies:** There is inconsistent and unclear guidance from TPAs on funding for uninsured clients, particularly regarding the specific amount available per client. MPGs are being notified that they have reached the maximum available for uninsured clients. In some cases, TPAs are refusing to pay consultants for services provided to uninsured clients. This has resulted in physicians and hospitals requiring uninsured clients to pay block fees prior to accepting uninsured midwifery clients or refusing care of uninsured clients all together. This leads to delays in or denials of care, potentially resulting in avoidable adverse health outcomes and an increase in emergency department visits, which further strains the healthcare system. It also places an administrative burden on midwives, who are left to follow up on payments for consults, making it administratively onerous on providers.

2. **Unclear Eligibility for Uninsured Midwifery Funding:** There is a lack of clarity regarding who qualifies for uninsured midwifery funding. For example, international students who are Ontario residents with health insurance through their college/university are often regarded as ineligible. However, their school's insurance plan often has limitations whereby pregnancy and childbirth are not covered. If the student is a resident of Ontario, and if their insurance does not cover pregnancy and delivery, then they should receive uninsured funding. Clarity on the eligibility for uninsured funding will improve integration of services particularly for international students and those with precarious employment (i.e., migrant workers) or housing status, who are residents of Ontario[1] but have limited private insurance coverage that does not extend to pregnancy care.

3. **Cost Per Uninsured Client:** The uninsured midwifery program was developed with the understanding that the average cost of an uninsured client may be approximately $1,953. This average cost was agreed to in 2014, and should be updated to reflect changes such as, changes in tests/procedures, increase in costs, inflation, etc. Although in 2014 the agreement stated this average cost was not a cap, some TPAs are using this average cost as a justification to suggest there is a "funding cap per uninsured client".

4. **Newborn OHIP Eligibility:** Newborns of uninsured clients are being denied OHIP coverage at hospitals and Service Ontario, and midwives are allocating substantive time advocating for their clients. Consistent adherence to infant OHIP eligibility criteria is

[1] As per Ontario's Health Insurance Act definition of primary residence: ""primary residence" means the place with which a person has the greatest connection in terms of present and anticipated future living arrangements, the activities of daily living, family connections, financial connections and social connections, and for greater certainty a person only has one primary residence, no matter how many dwelling places the person may have, inside or outside Ontario." O. Reg. 664/98 FISH LICENSING | ontario.ca

essential, despite the birthing parent's insurance status – which is not a factor that determines eligibility.

Eligibility criteria for issuance of OHIP:

1. Infant is born in Ontario
2. Infant will be living in Ontario for 153 days in a 12-month period
3. Ontario is the primary place of residence of one parent/custodian

5. **Uninsured funding mechanism for EMCMs:** There is no mechanism for midwives working with Expanded Midwifery Care Models to access uninsured funding. EMCMs were designed to enhance access to primary care and to fill gaps in community health for priority populations (this may include priority populations beyond 8 weeks postpartum). While a few EMCMs affiliated with a CHC may be able to register clients to the CHC to access certain services, this does not adequately meet the need for routine prenatal care or the ability to access necessary tests and consults in every setting where it is needed. EMCMs face challenges accessing the uninsured funding across different settings, with most only being able to do so because of their affiliation with a CHC or another special arrangement, not through a system-wide solution.

6. **Inconsistent access to uninsured funding for Schedule Q and R:** Schedule Qs and Rs are affiliated with an MPG that has a TPA letter for uninsured clients. Without clarity from the MOH, TPAs have been inconsistent with approving Schedule Q and R programs to access uninsured funding.

Risks of status quo for Ontarians:

- Delayed access to healthcare for uninsured pregnant people, leading to avoidable complications, more severe illness, and mortality.
- Increased costs to the healthcare system when uninsured people arrive in hospital, including emergency room visits with complications that could have been averted with access to routine prenatal care.
- Denial of care and insurmountable debt for uninsured pregnant people.
- Increased rates of vaccine-preventable illnesses and critical illnesses of newborns denied OHIP, if parents are not able to vaccinate their infants or seek appropriate care.Risks for health care providers and the health care system:
- Distress experienced by midwives and other healthcare providers unable to provide medically indicated care due to funding issues or when having to make a financial decision rather than a clinical decision. This significantly impacts sustainability and contributes to provider burnout.

- Administrative burden related to helping patients navigate access to and payment for medical services, which diverts providers from delivering primary care services.
- Barriers in accessing midwifery care through uninsured funding can lead to poorer health outcomes for uninsured pregnant people and infants, and lead to challenges navigating the fragmented and complex healthcare system or reliance on emergency services. This adds a further strain on the healthcare system when these individuals ultimately end up in hospital emergency departments with preventable or more severe complications.

Benefits of restoring OMP-AOM commitments

- **Supports Ontario Health's aim** to create an equitable, integrated and connected system that ensures all Ontarians receive the right care, in the right place at the right time[2] – this includes Ontarians without health insurance.
- **Improves timely access to primary care** for pregnant people and newborns residing in Ontario, which reduces costly hospital visits and admissions, easing the strain on the broader healthcare system.
- **Reduces public health burden** by ensuring newborns have timely access to essential care, including vaccinations which help to reduce preventable health issues and lessen the burden on public health resources.
- **Ensures consistency and quality of care across Ontario**. Restoring commitments will create consistency across TPAs and MPGs, ensuring that seamless, high-quality care is provided in alignment with the OMP and AOM's original commitments.

Recommendations:

1. **Communication to TPAs to ensure consistency with disbursement of uninsured funding**: The AOM recommends providing clear guidance to TPAs regarding payment to consultants to ensure they are paid at the OHIP rate, ensure funding follows the medical needs of the client and that it is seamless at point of care. Additionally, TPAs should be reminded that they can reallocate funds to cover higher cost services and request additional funds from the OMP on a case-by-case basis if needed. TPAs should not refuse payment for uninsured midwifery client consults. Physician consultants and labs should feel confident that they will get paid the full amount that they would bill OHIP under the Schedule of Benefits and receive payment in a timely way. The system should not be administratively onerous on consultants and midwives having to self-advocate or follow up on payments for consultants.

[2] Our Work – Transforming Health Care – Ontario Health

2. **Clarity on eligibility criteria:** The AOM recommends providing clear guidelines around who qualifies as an uninsured Ontario resident. As per Ontario's Health Insurance Act, the primary place of residence is defined in the law as the place where "a person has the greatest connection in terms of present and anticipated future living arrangements, the activities of daily living, family connections, financial connections and social connections." This clarity is particularly important when considering eligibility for international students without pregnancy coverage through their health insurance plans, and vulnerable residents such as those experiencing houselessness or living in shelters who may not have a permanent residential address they can provide to a midwife. Clear eligibility criteria from the MOH would ensure consistent care across the midwifery sector and improve efficiency in TPAs operationalizing the program.

3. **Ensure the cost per client is reflective of the current cost of care:** The AOM recommends increasing the $1,953 calculated in 2014 to reflect current costs of lab tests and consultations and include additional OHIP-covered tests that have been added since 2014.

4. **Directive to adhere to newborn OHIP eligibility criteria:** Hospitals and Service Ontario offices would benefit from communication reinforcing the eligibility criteria for newborns to receive OHIP. Examples of reasons for OHIP denials include requiring both parents to have OHIP, hospitals requiring some clients to go to Service Ontario to obtain OHIP, or Service Ontario demanding proof of permanent residency, refugee status or a valid work permit from parents. These practices not only violate newborn OHIP eligibility requirements but also pose a public health and safety risk, along with potential liability and increase strain on the healthcare system if newborns become ill and are unable to access essential services due to wrongful OHIP denials. A clear directive from the Ministry to hospitals and Service Ontario is necessary to prevent these denials caused by inconsistent staff determinations.

5. **Uninsured funding mechanism for EMCMs:** The AOM recommends that the OMP develop a mechanism for EMCMs to access uninsured funding (i.e., a letter for EMCMs equivalent to the TPA letter available to MPGs)

6. **Schedule Q and R:** The AOM recommends the OMP provides clear direction to TPAs that Schedule Qs and Rs can utilize the same TPA letter that is associated with the MPG they are affiliated with.

7. Inclusion of the terms of the uninsured midwifery funding in the Memorandum of Understanding of the TPA-MPG Agreement to ensure clarity and consistent implementation across all TPAs.

Appendix 1: Uninsured Funding Meeting Notes

Uninsured Funding

Meeting Summary Notes

Date: March 12, 2015

Time: 10:00-11:00 AM

Present

Manavi Handa	RM
Richard Yampolsky	OMP
Rosabelle Sankar	OMP
Kelly Stadelbauer	AOM
Talia Bronstein	AOM

Program Implementation

There was agreement to the underlying principles of the uninsured funding:

- Funding should follow the medical needs of the client and should be seamless at point of care
- No service providers should be concerned that they will not get paid
- Payment should be equal to the amount the service provider would earn with an OHIP insured client, and should be issued in a timely fashion
- There should be checks and balances in place to ensure accountability and valid billing
- The system should not be administratively onerous on health providers

The implementation of the uninsured funding was discussed as follows:

- MPGs will notify their TPAs of their projected uninsured client numbers, based on the previous year. The TPA would multiply $1,953 by the number of projected uninsured clients to determine how much funding they need each year.
- The OMP will over-allocate funds to TPAs to ensure there is sufficient funding, and the TPA can return unused funds quarterly (instead of the TPA needing to request additional funds if there are higher numbers of uninsured clients, or if a single client greatly exceeds $1,953).

- If a client is highly complex and will likely exceed $1,953, the MPG will notify the TPA as soon as they are aware, so they can prepare for the higher cost.
- The MPG and TPA will communicate on a quarterly basis to discuss utilization rates.
- Midwives will have uninsured clients sign a consent form that gives permission to share information with the TPA
- Midwives will attach a letter to the physician/consultant/diagnostic service request that explains how the provider will be paid. Service providers will be required to list the Schedule of Benefits code on their invoice.
- The TPA will verify the Schedule of Benefits code on the invoice and provide payment to the service providers.
- There may be a delay in payment in early 15/16 as BORN cannot set up the payment system until May 2015; but payments will be retro to April 1, 2015.
- The program will be evaluated using BORN data after the first year to see whether the funding was sufficient in each category and if there were any barriers to implementation.
- If the program is ever cancelled, the OMP will continue to fund the clients who were taken into care before the cancellation was announced.

Other discussion:

- The AOM recommended that the TPA send the MPG a list of clients they have received bills for each quarter so the MPG can verify they are indeed midwifery clients. This verification system will support accountability.
- M. Handa discussed the possibility, after the first year of the funding, of conducting an evaluation that uses all the invoices submitted in that year. This will provide more information than the data fields collected through BORN.
- There was a recognition that this program will increase the administrative work of the TPAs
- The Ministry would entertain a proposal from the AOM that would support education to OBs, ultrasound technicians, anesthesiologists, surgical assistants and ER staff about the uninsured funding.

Follow up items:

OMP:

- Notify the AOM after the legal counsel provides feedback on the template letter

- Notify the AOM as to whether it is possible to extend the March 19, 2015 billing deadline by setting up an accounts payable with the TPA so the TPA can accrue the cost beyond the fiscal year deadline.
- Find out and notify to AOM what client information the TPA can see in BORN (unique client identifier vs. personal identification)

AOM:

- Remove the word "all" from the final sentence of paragraph 2 of the template letter
- Check whether the current consent letter covers personal information being shared with the TPA (to enable payments for uninsured expenses between Jan 1-March 31, 2015).
- Consider a new consent letter to be rolled out April 1, 2015 specific to uninsured clients
- Consider a grant proposal regarding educating providers about this new funding

Appendix 2: Letter from Richard Yampolsky

From: Yampolsky, Richard (MOHLTC) <Richard.Yampolsky@ontario.ca>
Sent: Friday, March 27, 2015 4:58 PM
To: Undisclosed recipients:
Subject: Payment Process for Uninsured Midwifery Clients

Dear TPAs and MPGs,

The ministry has been working with the AOM to resolve payment processes for midwives' uninsured clients to access third party services, including diagnostic tests, consultations, referrals and transfers of care. There are two processes detailed below – for the period January 1, 2015-March 31, 2015 and for April 1, 2015 onwards.

For **January 1, 2015-March 31, 2015**, there has not been a process to allow service providers (physicians, labs, etc.) to invoice TPAs directly. As a result, some individual clients and MPGs have incurred allowable expenses and currently have invoices awaiting payment. The ministry is asking for the TPAs to understand the unique circumstances for this period of time and help expedite payments for this period. The following steps will be followed:

1. Midwives/MPGs will obtain signed consent from their uninsured clients to disclose personal health information for billing of physicians and laboratory/diagnostic services and provide it to their TPA. The consent form (attached, also available from the AOM website) has been provided by the AOM for its members' use. MPGs should put the contents of this form on their own MPG letterhead.

2. Midwives/MPGs will provide TPAs with any outstanding allowable invoices [their client's or their own] for payment by **May 15, 2015**.

3. TPAs will reimburse MPGs for services rendered between January 1 and March 31, 2015. For invoices received during this period, the ministry is asking TPAs to be flexible and issue payment to individual clients for allowable invoices. [During this period some clients may have provided payment directly] MPGs are responsible for ensuring that TPAs have correct contact information for any clients seeking reimbursement directly.

4. Payment amounts should correspond with Schedule of Benefit fee codes. (The ministry will be providing TPAs with these details shortly).

5. As I indicated in my email to TPAs earlier this month, if your TPA has not received invoices and issued payments prior to March 31, 2015, your TPA can accrue these amounts as "accounts payable" and issue payments later.

Starting **April 1, 2015**, this new process is to ensure funding accountability and will involve the following 3 steps:

1. Midwives/MPGs will obtain signed consent from their uninsured clients to disclose personal health information for billing of physicians and laboratory/diagnostic services and provide it to their TPA. The consent form (attached) has been provided by the AOM for its members' use. MPGs should put the contents of this form on their own MPG letterhead.

2. Midwives/MPGs will complete the "uninsured letter" (attached, also available from the AOM website) indicating that the uninsured client is under their care, is a resident of Ontario without OHIP coverage, and requesting medically necessary services. The letter explains how the provider will be paid. Midwives/MPGs must attach the letter to the physician/consultant/diagnostic service request forms that they provide to their uninsured clients. It is the client's responsibility to provide the referral and letter to the service provider.

3. TPAs will issue payment for invoices within a reasonable timeframe following receipt. TPAs will issue payment to service providers, *not* to individual clients.

   In order to receive payment, service providers' invoices to the TPAs must include:

   - The uninsured letter
   - The patient's name, and date of service
   - OHIP billing codes and procedure name
   - Diagnostic Fees with appropriate Schedule of Benefits code
   - Specialist Fees with appropriate Schedule of Benefits code

   The maximum allowable cost per service is the amount payable under the Schedule of Benefits. The uninsured midwifery client is eligible for funding to cover her pregnancy related third-party services for the full extent of her time in midwifery care (e.g. 8 weeks after her EDD), including:

   - Obstetrical Referral/Consultation/Transfer (prenatal, intrapartum, postpartum)
   - Anesthetic Referral/Consultation
   - Surgical Assist
   - Referrals to "other" physicians (e.g. endocrinology, hematology, urology)
   - Lab work (e.g. routine prenatal blood work, glucose testing, GBS)
   - Prenatal Genetic Testing (IPS/FTS)

Note: This program is based on an average cost of $1,953 per client. In the event that a client is highly complex and may require services that will exceed $1,953, it is the MPG's responsibility to notify its TPA as soon as possible. TPAs will have the flexibility within their uninsured clients' budgets to assign additional funds on a case by case basis.

Please contact me if you have any questions regarding this new process.

Richard Yampolsky

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Primary Health Care Branch - Salaried Models and Programs

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