Date: March 30, 2011

To: Physicians of Provider Led Family Health Teams

From: Adam Farber, OMA Legal Counsel

Subject: FHT Funding Agreement

The Ontario Medical Association (OMA) has received numerous inquiries from Physician-Led Family Health Teams (FHTs) regarding the FHT Funding Agreement recently distributed by the Ministry of Health and Long-Term Care (the "Ministry"). The OMA was involved in the negotiations of the original Interim FHT Funding Agreement (IFA) under which FHTs have been operating to date. The Ministry intends to replace the IFA with this permanent FHT Funding Agreement. The Ministry was not willing to negotiate the terms of this Agreement with the OMA, as it did when developing the IFA. The OMA raised several concerns regarding the original draft provided by the Ministry, and the OMA was successful in achieving amendments on certain terms. However, there remain several key areas of the distributed FHT Funding Agreement that present legal concerns.

This memo comments on the significant changes in the FHT Funding Agreement when compared with the IFA. However, as every FHT is different, each FHT should obtain appropriate legal advice regarding how this Agreement will impact it.

Recipient's Obligations

The "Recipient" is the party to the Agreement. Hence, it receives the funds from the Ministry under the FHT Agreement. In exchange, the Recipient FHT is required to fulfill various obligations under the Agreement.

If the Recipient is incorporated, it is the legal entity that is the party to this Agreement — not the individual physicians who provide clinical services at the FHT. Thus, the legal

risks and responsibilities of entering into the Agreement are borne by the FHT. The officers and directors of the corporation are not personally responsible for corporate liabilities, except for certain liabilities imposed by legislation[i], such as:

(a) *Corporations Act* (directors are personally responsible for 6 months' wages and up to 12 months of accrued vacation pay);
(b) *Employment Standards Act* (6 months' wages and up to 12 months of accrued vacation pay);
(c) *Income Tax Act* (unremitted withholding taxes);
(d) Employer Health Tax Act (unremitted taxes);
(e) *Employment Insurance Act* (unremitted premiums); and
(f) *Canada Pension Act* (unremitted payments).

However, FHTs can purchase insurance for such statutory liabilities.

FHTs that are not incorporated should consult with their legal advisors to assess their potential risk and to determine if incorporation is now advisable.

Given what has been explained above, it is unclear why some corporate FHTs received agreements containing sections 2.2 and 2.3. These sections set out the governance requirements for FHTs who consist of a "single pre-existing group" or groups consisting of a "combination of two or more physician groups". It is unnecessary for an incorporated FHT to develop the governance structure set out in these provisions because a corporation is governed by its by-laws and legislation.

Sections 2.2 and 2.3 state that in a FHT consisting of one physician group (e.g. a FHO), the lead and associate lead physicians shall "have the authority to bind all Recipients regarding matters involving this agreement", and the "Recipients shall be bound by the governance structure established pursuant to their Physician Services Contract." This does not make sense. A corporate FHT is a legal entity who signs the agreement with the Ministry, not the physicians. The FHT is bound by the terms of the agreement, not the individual physicians. Furthermore, the FHT is not a party to the governance arrangements between individual physicians in a "Physician Services Contract". It is impossible for the FHT to be bound by such an agreement.

Section 2.1 – Physicians

This section requires all physicians who are part of a Patient Enrolment Model (i.e. FHN, FHO, RNPGA) to also be members of the FHT, unless the Ministry provides an exception. It is our understanding that this exception would only be available in extremely limited situations. This policy differs from what was previously permitted, as physicians in a Patient Enrolment Model (PEM) did not have to be members or contracted to provide services to the FHT. This change could have a significant impact on some physicians and their PEM groups, as there may be cases where physicians wish to maintain their FHO contract status without having to work within the FHT structure.

Section 2.7 – Equal Access to Family Health Team Services

This section states that all patients enrolled to physicians affiliated with the FHT have "equal access to Family Health Team services including the services of the interdisciplinary health providers." To clarify, the Ministry has explained that this provision is intended to ensure that all patients associated with a FHT have the same ability to access the resources of a FHT. The Ministry's goal is to avoid situations where patients of a particular physician or office have exclusive access to some FHT resources (e.g., access to a dietician, or social worker). This provision may require FHTs to reorganize their resources and programs.

Section 3.8 – Hiring of FHT Staff

This section explains that all positions under the FHT shall be employees of the FHT, "unless the Ministry has provided its written consent for the use of an individual or individuals to be hired as an independent contractor."

Thus, if a FHT has hired staff members as independent contractors and wish to continue this relationship, and/or if a FHT wishes to retain the services of an

independent contractor, the FHT should make a formal request to the Ministry to obtain written consent to continue or enter into an independent contractor relationship.

Section 3.9 – Enrolment Targets

This section requires FHTs to meet enrolment targets as a condition of funding. Section 3.9 states:

"The Ministry's section 3.2 right to suspend payment of Funds pertaining to any item in Schedule "B", shall include the right to suspend any portion of the IHP Funding during a funding year, where the Ministry, in its reasonable discretion, determines that the Family Health Team is unlikely to achieve its stated patient enrolment commitments by the end of the funding year." [emphasis added]

This section explains that the "stated patient enrolment commitments" are the commitments a FHT made in its original business case when it applied to the Ministry to participate in the FHT initiative. Thus, each FHT should review its original business plan to confirm the enrolment targets set out in Schedule "B" of their agreement are the same as the original commitment.

If the FHT is requesting new or additional funds from the Ministry, the Ministry may have increased the enrolment commitment. The Ministry has previously explained that the determination of roster targets considers the following factors:

(a) Community of the FHT;
(b) population of that community;
(c) cultural factors of patient populations in the community; and
(d) physician's style of practice (i.e. GPs also providing emergency work, deliveries, other specialty services, and academic commitments).

If a FHT feels that that these factors have not been considered by the Ministry and the enrolment target is too onerous, the FHT should contact its Ministry representative to discuss the appropriate enrolment target.

Section 4.6 – Termination

This section marks a significant change from what was set out in the IFA. Section 4.6 of the IFA stated:

"In the event that either party terminates this Agreement, the Ministry agrees to compensate the Recipient for any amount(s) required by the Recipient to terminate the obligations which it has entered into pursuant to this Agreement."

The new FHT Funding Agreement states that the Ministry will only be obliged to compensate the FHT where the Ministry terminates the Agreement. If there is a change in the FHT's circumstances (which could be caused by a change in Ministry policy) that would require the FHT to terminate the Agreement, the Ministry would not provide funds to satisfy the FHT's ongoing commitments. Thus, if a FHT contemplates terminating this Agreement, it is important for it to understand its commitments and obligations so as to limit or eliminate any exposure to contractual liability.

Section 10.3 – Limitation of Liability

This provision states that the FHT agrees to accept all damages, losses, liabilities, etc., caused by anyone associated with the FHT (i.e. employees, agents, officers, directors, etc.). The Ministry has stated that this provision is necessary to meet requirements established by "MGCS/Risk Management Direction." This provision creates a risk for the FHT, as it requires the FHT to assume the risk of liabilities caused by third parties (e.g., FHT employees) for things it would not ordinarily be responsible for.

At common law, an employer may be vicariously liable for the actions of its employees when acting within the scope of their employment. An employer will not be responsible for any other liability caused by an employee. This section states that the FHT will accept responsibility for liability on the part of the employees, staff, officers, directors, etc., with no limitation. This is a highly unusual provision.

This could expose the FHT to any and all liabilities caused by that individual, regardless of the liability relating to his or her FHT responsibilities. It is uncertain if there are any insurance companies that sell policies to cover a scope of activities this broad. Existing insurance policies are typically limited to the scope of FHT operations.

Section 11.1 – Recipient Indemnification

This indemnification provision did not exist in the IFA. This section explains that the FHT will agree to protect the Ministry from any claims brought against it as a result of the actions of the FHT. The protection the FHT grants the Ministry is limited to the extent to which the insurance policies described in section 11.2 respond to claims. The protection does not extend to claims caused by the Ministry. It should be noted that the FHT is responsible for protecting the Ministry for "all claims, causes of actions, demands, liabilities…attributable to anything done or omitted to be done by the Recipient…" This means that the FHT is responsible for any outcome. This is unusual for a commercial agreement. Typically, indemnification is limited to negligence or wilful conduct.

Sections 13.1 & 13.2 – Dispute Resolution

These provisions state that the FHT is required to have various mechanisms in place to deal with disputes and complaints. In our discussions with the Ministry, the OMA did not understand the need for these mechanisms, as most of the issues would be addressed via governance (e.g., corporate bylaws) and contracts (e.g., employment agreements). However, the Ministry insisted on their inclusion in the Agreement. Thus, each FHT should ensure that appropriate dispute mechanisms are put in place, and if new policies are adopted, that they are consistent with any governing documents and/or contracts.

Conclusions

As indicated above, the risks inherent to the FHT Funding Agreement are borne by the FHT. In most cases, the FHT is a corporate entity. For the most part, physicians associated with FHTs are inherently protected by corporate FHTs.

Each FHT must review the new FHT Funding Agreement to evaluate the level of risk it may be exposed to. If a FHT determines that this Agreement is problematic, the concerns should be brought to the attention of the Ministry to determine whether they can be addressed. It is our understanding that it is unlikely that the Ministry is willing to make any amendments to this Agreement. If this is the case, and the FHT has significant concerns regarding this Agreement, the FHT may have to make a difficult decision as to whether it wishes to continue its participation in the FHT initiative.

[i] With rare exception i.e. where a court is willing to "pierce the corporate veil" which generally only occurs in cases of directors' fraud.