Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PHYSICIAN BILLING

(SECTION 3.11, 2016 ANNUAL REPORT OF THE OFFICE OF THE AUDITOR GENERAL OF ONTARIO)

2nd Session, 41st Parliament
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The Honourable Dave Levac, MPP
Speaker of the Legislative Assembly

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Ernie Hardeman, MPP
Chair of the Committee

Queen's Park
February 2018

Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS
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2nd Session, 41st Parliament

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CONTENTS

PREAMBLE

On March 29, 2017 the Standing Committee on Public Accounts (the Committee) held public hearings on the audit of Physician Billing, section 3.11 of the Office of the Auditor General of Ontario (the Auditor)'s 2016 Annual Report. Senior officials from the Ministry of Health and Long-Term Care participated in the hearings. (For a transcript of the Committee proceedings, please see Committee *Hansard*, March 29, 2017.)

The Committee endorses the Auditor's findings and recommendations and presents its own findings, views, and recommendations in this report. The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with written responses to the recommendations within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly, unless otherwise specified.

ACKNOWLEDGEMENTS

The Standing Committee on Public Accounts extends its appreciation to officials from the Ministry of Health and Long-Term Care for their attendance at the hearings. The Committee also acknowledges the assistance provided during the hearings and report writing deliberations by the Office of the Auditor General of Ontario, the Clerk of the Committee, and staff in the Legislative Research Service.

BACKGROUND

As of March 31, 2016, about 30,200 physicians (16,100 specialists and 14,100 family physicians) were providing health services to more than 13 million Ontario residents at a cost of $11.59 billion (2015/16). This is 20% higher than the $9.64 billion paid to physicians in 2009/10. The amount paid through fee-for-services has also increased by almost 20%, from $5.33 billion in 2009/10 to $6.38 billion in 2014/15, primarily as a result of the increased number of physicians who billed fee-for-service, from about 24,200 in 2009/10 to 28,100 in 2014/15.

Physicians operate as independent service providers and are not government employees. Their services are billed to the Province under the Ontario Health Insurance Plan (OHIP) as established under the provincial *Health Insurance Act*.

The Ministry of Health and Long-Term Care (Ministry) is responsible for establishing policies and payment models to fairly compensate physicians, while ensuring cost-effectiveness. The Ministry—through various divisions with 260 staff and an annual budget of about $27.9 million—administers payments to physicians and ensures that billings are appropriate. The Negotiations and Accountability Management Division has the main role in overseeing this billing process.

Physicians in Ontario can bill under three major models (excluding the salaried physician model):

- **Fee-for-service (FFS)—**$6.33 billion (2015/16). Physicians are compensated with a standard fee for each service they perform. Doctors bill using fee codes in OHIP's Schedule of Benefits. This model has been the principal way that physicians bill since 1972. It is widely used today, mainly by specialists.

- **Patient-enrolment Models (PEMs)—**$3.38 billion (2015/16). Physicians in group practices such as Family Health Organizations (FHOs) and Family Health Groups (FHGs) are paid based on patient enrolment and for a predetermined basket of services. The objective is for family physicians to offer their patients more comprehensive and continuous care. Remuneration might also include a combination of bonuses, incentives, and other payments for additional work including FFS payments for services outside the basket of services. The PEM model generally allows family physicians to earn more than the FFS model. As of March 31, 2016, 8,800 out of 14,100 family physicians had opted for one of the PEMs (FHOs and FHGs accounted for 92% of the total number of enrolled patients).

- **Alternative Payments Plans (APPs)—**$1.88 billion (2015/16). Physicians enter into APPs and other contracts with hospitals and physician groups to provide specific services, including physician training, research, emergency and/or other care in hospitals, and working in remote areas.

AUDIT OBJECTIVES AND SCOPE

The objective of the audit was to assess whether the Ministry had effective systems and procedures in place to

- ensure that fees paid to and recovered from physicians are appropriate and in accordance with applicable legislation, regulations, and agreements; and

- measure and report on how effectively physician payment models meet the needs of Ontarians.

Audit fieldwork was conducted from October 2015 to May 2016. Audit work was conducted primarily at the Kingston and Toronto offices of the Ministry's Negotiations and Accountability Management Division. In conducting its audit, the Auditor reviewed relevant documents, analyzed information, interviewed appropriate Ministry staff, and reviewed relevant research from Ontario and other Canadian provinces, as well as jurisdictions in other countries. The majority of the file review went back three to five years, with some trend analysis going back as far as 10 years.

MAIN POINTS OF AUDIT

The audit found Ontario physicians have been among the highest paid in Canada over the last five years. While one reason for this is that Ontario has the third-highest population-per-physician ratio, it also compensates more physicians than other provinces with models such as the patient-enrolment model (PEM)—a more expensive model than fee-for-service (FFS). Over the years, physicians were paid additional incentives even after reviews concluded that some of these payments likely did not improve the quality of patient care.

There were four objectives when Ontario decided to implement the patient-enrolment model: to increase patient and physician satisfaction, cost-effectiveness, access to care, and quality and continuity of care. However, use of PEMs had still not translated into increased access to care as measured by wait times—57% of Ontarians waited two days or more to see their family physician in 2015/16 as compared to 51% in 2006/07. Ministry survey data for the period October 2014 to September 2015 showed that approximately 52% of Ontarians found it difficult to obtain medical care in the evening, on a weekend, or on a public holiday without going to a hospital emergency department.

The Auditor's review of Ministry data noted that in 2014/15 each physician in an FHO worked an average of 3.4 days per week, while each physician in an FHG worked an average of four days per week. In 2014/15 60% of FHOs and 36% of FHGs did not work the number of weeknight or weekend hours required by the Ministry. Also, the Auditor noted that many patients were visiting walk-in clinics for care that could normally be provided by family physicians. The Ministry's survey data for October 2014 to September 2015 showed that approximately 30% of Ontarians had visited a walk-in clinic in the last 12 months.

The Ministry is also having challenges managing and controlling the use of services billed under FFS. While cost savings can be achieved by encouraging physicians, based on clinical research, to reduce medically unnecessary services, the Ministry's success in facilitating such reductions has been limited. In 2015 the Ministry implemented across the board cuts to physician payments, which the Auditor noted, is not a sustainable way to contain costs.

Another way to manage costs is to adjust FFS rates based on new clinical practices—an area where Ministry attention is still needed. Further, the Auditor noted that the Ministry's oversight and recovery of inappropriate FFS payments is weak, hindered by its lack of an inspection function and its ineffective enforcement of payment recovery mechanisms.

ISSUES RAISED IN THE AUDIT AND BEFORE THE COMMITTEE

Significant issues were raised in the audit and before the Committee. The Committee considers the issues below to be of particular importance.

Patient-enrolment models

The Auditor recommended that the Ministry review the base capitation payments and make any necessary adjustments in order to ensure that the fees paid are

justified for the basket of services physicians actually provide to their enrolled patients.

The Committee heard that the Ministry has started an analysis of the current base rate capitation payment along with fee schedule codes that should be removed from the basket of services included in the capitation payment and those that should possibly be removed from the basket of services. The Ministry is targeting to have the analysis completed by March 31, 2018. The Ministry also noted that adjustments to the capitation rate would require the Ministry to engage with the Ontario Medical Association (OMA) through the negotiations and consultation processes of the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement.

The Auditor recommended that the Ministry clearly define indicators to measure quality of care for enrolled patients, establish targets that the patient-enrolment models should achieve within a given period of time, and collect and publish relevant and reliable data to monitor and assess performance against targets on a regular basis.

In response to the above recommendation, the Ministry noted that it is working with Health Quality Ontario (HQO) and was making progress on its commitment to ensure that patients and the public have a clear understanding of how the health system is performing through HQO's yearly report, *Measuring Up*. The Ministry added that it will continue to work with HQO to define primary care performance measurement priorities and implement mechanisms for regular and transparent public reporting.

The Auditor noted that the Ministry should clearly define the minimum number of regular hours (including evening and weekend requirements) in every patient-enrolment contract and ensure that contract requirements were met.

The Committee heard that the Ministry has begun a policy and contract review to evaluate whether the current enrolment-related provisions are sufficient to encourage better access for enrolled patients. The Ministry stated that it will develop a regular monitoring protocol to determine whether physicians participating in enrolment models are meeting all the regular and after-hours requirements. The Ministry is aiming to have the monitoring protocol developed by October 1, 2017 and implemented by April 1, 2018. The Ministry intends to develop a performance management system for groups not meeting contract requirements that could include monetary penalties. The Ministry is targeting to have the performance management system developed by October 1, 2017 and implemented by April 1, 2018. At the time of writing, this is still under negotiation.

The Ministry added that enabling the Auditor's recommendations would require contract amendments. Contract amendments including a minimum number of regular hours and consequences for not meeting contract requirements would require the Ministry to engage with the OMA through the negotiations and consultation processes.

Continuity of primary care

The Auditor recommended the Ministry explore different options, such as requiring that patient records be shared between physicians to improve coordination of care for patients.

In response, the Ministry stated that it is reviewing options for sharing patient health data in an effort to improve coordination of care for patients receiving care by more than one physician. The target date to have the review of options completed by is April 1, 2018. Through its Digital Health Strategy, the Ministry has developed and implemented a number of digital health solutions to help physicians share records and improve care coordination. Notable solutions include

- Ontario's Connected Backbones, which are core provincial digital health infrastructure and allow clinicians to access information shared by hospitals, laboratories, and other sectors of the health system (the Backbones are designed to eventually enable data sharing outward from primary care);

- Hospital Report Manager, which enables timely clinical follow-ups after a patient is discharged from hospital by sending hospital discharge reports directly to their primary care physician's electronic medical record; and

- eNotification, which supports integrated patient care by sending near real-time alerts to clinicians when their patients visit an emergency room or are admitted or discharged from hospital.

Further, the Ministry is exploring additional options to enable primary care practices to share data for better patient care. Notable examples include

- expanding access to Connected Backbones to allow more physicians to view data contributed by others, and piloting innovative ways to share data outward from primary care;

- looking for opportunities to send more information through Hospital Report Manager in the future, including the potential to include continuity of care by sending reports from walk-in clinics to primary care providers when patients visit an after-hours clinic;

- increasing data sharing between primary care electronic medical records and other applications, potentially including consumer applications, by investigating the feasibility of using modern open application programming interface (APIs); and

- exploring opportunities and interest in regional shared services for primary care technology provision where applicable, which could provide patients with one regional primary care health record accessible by all providers sharing the system.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

1. **The Ministry of Health and Long-Term Care**

    a) **expand access to Connected Backbones to include all primary care providers;**

    b) **ensure that all primary care providers are given the necessary training on the use and management of Connected Backbones;**

    c) **ensure that data is also shared outward from primary care providers to Connected Backbones; and**

    d) **provide a timeline for implementation of the above.**

Use of emergency department services for non-urgent care

The Auditor recommended the Ministry should evaluate whether existing after-hours services offered by contracted physicians were sufficient, educate patients on non-urgent care options, and consider best practices from other jurisdictions with respect to after-hours care.

In a proposal given to the OMA in December 2016, the Province committed to providing additional support to family doctors, and to working with family doctors to ensure that patients receive more timely access to their services. Subsequently, the OMA and Ministry have agreed to begin negotiations for a binding dispute resolution process and a new Physician Services Agreement. Changes proposed in December 2016 are on hold until this process is completed. Additional supports to family doctors in providing appropriate after-hours care based on the needs of their rostered patients may be negotiated as part of a new Physician Services Agreement.

Negotiations are still underway for a new Physician Services Agreement.

The Ministry added that it has and would continue to consider best practices of other jurisdictions to inform all of the above. Jurisdictional scans are embedded within the Ministry's policy development processes, as they are a key input that helps to ensure that the Ministry's activities are informed by the best evidence available.

Further, the Ministry stated that it was considering a patient education campaign to reinforce the value of continuity of care, of seeing one's regular provider, and highlighting the drawbacks of walk-in clinics and emergency departments. This campaign would follow the implementation/execution of amended physician funding agreements. The Ministry added that it would engage with the OMA through the negotiations and consultation process of the Representation Rights and Joint Negotiation and Dispute Resolution Agreement with a view to strengthen access and information sharing requirements through amendments to the physician funding agreements.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

2. **The Ministry of Health and Long-Term Care**

   a) **develop and distribute educational resources to the public that provide guidelines and information about non-urgent care;**

   b) **track the number of patient visits to emergency departments for non-urgent care to assess the effectiveness of the educational campaign; and**

   c) **adjust, if necessary, and repeat the campaign until a satisfactory level of patient visits to emergency departments for non-urgent care is achieved and sustained.**

Variance in physician payments

The Auditor noted that the Ministry should obtain accurate information on physicians' practices, including their operating cost and profit margin in providing OHIP services.

The Committee heard that the Ministry did not have the ability to collect this information at that time. The Ministry added that it has begun reviewing the feasibility of obtaining accurate information on overhead that can be independently verified. The Ministry stated that it would consult further with the OMA on this recommendation.

The Committee believes that it is important for the Ministry to have access to reliable data and that negotiations should not trade off oversight and accountability.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

3. **The Ministry of Health and Long-Term Care**

   a) **establish ranges for average payments to physicians by medical specialty;**

   b) **regularly track and identify reasons when payments to physicians exceed the average payment within the same specialty; and**

   c) **obtain accurate information on physicians' practices, including operating costs and profit margins.**

Implementation of patient-enrolment models

The Auditor recommended that the Ministry should implement the recommendations from its policy review on the access bonus, and redesign the bonus so that the Ministry does not pay for duplicated services.

The Committee heard that the Ministry is reviewing the documentation received by patients and physicians regarding enrolment commitments. The Ministry added that it is reviewing the access bonus and this review includes a determination whether any changes to the hold back are necessary. The Ministry has set a target of July 1, 2017, to have the patient education review completed with any recommended changes in place by April 1, 2018. The target date to have the review of reporting received by physicians on patients receiving services outside the group is also July 1, 2017 with recommended changes in place by April 1, 2019. The target completion date to have the review of the access bonus including the determination whether any changes to the hold back are necessary is April 1, 2017. The Ministry added that enabling these recommendations would require contract amendments. Any change to the access bonus would require the Ministry to engage with the OMA through the negotiations and consultation process.

The Auditor recommended that the Ministry should review its capitation payment policies and pay capitation payments, premiums and incentives only where justified with evidence.

In response, the Ministry reiterated that it is conducting a review of the capitation rate, including evaluation of the core services provided to patients by physicians who receive a base rate capitation payment. The Ministry is targeting April 1, 2018, to have the review of the base capitation completed.

Oversight of fee-for-service payments

The Auditor recommended that the Ministry establish evidence-based standards and guidelines for each specialty to ensure all procedures and tests performed are medically necessary for patients, and provide better education to patients on the common procedures that are not evidence-based.

The Committee heard that Health Quality Ontario (HQO) had recently launched a Quality Standards program. The goal of the program is to reduce existing variations in practice across the province and improve quality care delivery through the development of standards that outline evidence-based best practices for specific conditions or system issues in relevant healthcare settings. The quality standards serve as a resource for clinicians to know what care to offer based on evidence and expert consensus and include statements that are specific to assessment, diagnostic procedures, and treatment modalities. Further, the standards include a clear, concise guide to assist patients, residents, families, and caregivers to know what to ask for in their care. The aim is to encourage dialogue between clinicians and patients, and to ensure information is both consistent and accurate when it is shared with patients and caregivers and within the inter-professional care team. Finally, the program also approaches each standard from the perspective of quality improvement and identifies potential support and changes required to support the use of the standards. In

some situations, this may also identify opportunities to adjust how services are funded in the province.

HQO also supports Choosing Wisely Canada (CWC), a program aimed to help clinicians and patients engage in conversations about unnecessary tests, treatments, and procedures. Being focused on appropriate care and decreasing the use of tests that are unnecessary and potentially introduce risk to patients, this program supports the objectives of more appropriate physician services and subsequent billing. CWC has released over 180 lists of matters clinicians and patients should question to support those conversations.

The Ministry added that it will continue to work with HQO on the Quality Standards program and CWC. The Ministry noted that standards established for physician services will inform funding decisions.

The Auditor recommended that the Ministry strengthen the oversight of fee-for-service payments to physicians by undertaking a number of measures such as re-establishing an inspector function, monitoring billings, and establishing a mechanism to recover overpayments.

In response, the Ministry noted that it has established a plan to increase, coordinate, and re-align staffing resources to monitor physician payments. Also, the Ministry is reviewing options for investment in information and information technology (I&IT) tools to monitor physician payments and perform data analysis. The Ministry stated that it is evaluating the costs and benefits, and feasibility of amending the fee-for-service billing review process and re-establishing an inspector function. The Ministry planned to complete the staffing changes by the summer/fall 2017 and to begin the implementation of I&IT investments in the fall of 2017. Lastly, the Ministry indicated that it is reviewing internal processes to make them more streamlined and effective.

The Committee believes that strong oversight of payments to physicians is necessary and the Ministry's ability to monitor payments and recover public funds against inappropriate billings should be strengthened.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

4. **The Ministry of Health and Long-Term Care**

    a) **establish formal ranges for reporting the results of its payments to physicians to the public;**

    b) **regularly track and monitor the accuracy of physician billings and compare these to the ranges; and**

    c) **ensure that inappropriate billings are recovered on a timely basis.**

Managing health-care services under the fee-for-service model

The Auditor recommended that the Ministry re-establish the Medical Services Payment Committee to provide regular reviews of physicians' fees and assess the impacts of technological advancements on treatment times.

The Ministry informed the Committee that it had invited the OMA to discuss a Schedule of Benefits review in December 2016. The Ministry expressed that it was open to re-establishing the Medical Services Payment Committee to review the Schedule of Benefits for Physician Services and added that discussions with the OMA were required.

Echocardiography services billing

The Auditor recommended that the Ministry work with the Ontario Association of Cardiologists and the Cardiac Care Network of Ontario to assess the effectiveness of the Echocardiography Quality Initiative (EQI), monitor the use of cardiac ultrasound services claimed by facilities, and recover the $3.2 million of overpayments to physicians related to the cardiac rhythm monitoring tests that were inappropriately claimed.

The Ministry informed the Committee the EQI was developed to assist facilities providing echocardiography services to achieve best practice standards for quality and care. The Ministry added that the EQI may also serve to deter inappropriate use of cardiac ultrasound services as facilities registered for the EQI cannot submit claims for these services.

The Ministry explained that the Cardiac Care Network (CCN) began providing quality assessment to registered echocardiography facilities in fall 2016. The Ministry added that accredited facilities billing for cardiac ultrasound services in Ontario would meet provincial quality standards. The CCN had also implemented protocols to ensure that quality assurance is maintained between quality reviews (every three years) and has a communication strategy in place to disseminate any changes to the EQI standards and practices. Communication to facilities about best practices and standards expected for achieving accreditation has been provided to registered facilities. Updates to accreditation process and best practices are provided via email and made available on the CCN's website. As of January 2017, 1,009 echocardiography facilities in Ontario were registered for an accreditation assessment.

Further, the Ministry stated that the CCN would continue to work with registered facilities to schedule assessments. Also, the Ministry added that it was reviewing its options under the *Health Insurance Act* to determine the appropriate course of action with respect to the recommendation to recover $3.2 million of overpayments to physicians.

Medical liability protection costs

The Auditor noted the Ministry should work with the Canadian Medical Protective Association and the OMA to review the recommendations of the third-party report on medical liability protection costs, and take any necessary actions to reduce the cost burden on taxpayers stemming from medical liability protection costs.

The Ministry informed the Committee that it has retained former Justice Stephen Goudge to conduct the third-party review and provide a report with recommendations for the Ministry's consideration. The Ministry stated that it expected to receive the report by summer 2017 and would review its recommendations upon receipt.

Committee Recommendations

The Standing Committee on Public Accounts recommends that:

5. **The Ministry of Health and Long-Term Care**

   a) **review the recommendations from the third-party report and provide the Committee with corresponding timelines for expected implementation dates;**

   b) **provide the Committee with its rationale for not implementing certain recommendations, if applicable; and**

   c) **provide the Committee with a copy of the third-party report.**

Physicians' legal costs in billing reviews

The Auditor recommended that the Ministry work with the Canadian Medical Protective Association (CMPA) and the OMA to ensure that taxpayer funds are not being used to reimburse physicians during Ministry billing reviews.

In response, the Ministry stated that it will review this matter in conjunction with the recommendations provided in the third party report being prepared by Justice Goudge. The Ministry added that it intends to pursue a billing review analysis of whether taxpayer funds are being used to reimburse physicians for CMPA fees related to CMPA assistance with Ministry billing reviews. If required, a plan to ensure that taxpayer funds are not being used in this manner will be developed.

Committee Recommendation

The Standing Committee on Public Accounts recommends that:

6. **The Ministry of Health and Long-Term Care provide the Committee with an update on the status of its billing review analysis and, if applicable, timelines for implementing changes.**

CONSOLIDATED LIST OF COMMITTEE RECOMMENDATIONS

The Standing Committee on Public Accounts recommends that:

1. **The Ministry of Health and Long-Term Care**

   a) **expand access to Connected Backbones to include all primary care providers;**

   b) **ensure that all primary care providers are given the necessary training on the use and management of Connected Backbones;**

   c) **ensure that data is also shared outward from primary care providers to Connected Backbones; and**

   d) **provide a timeline for implementation of the above.**

2. **The Ministry of Health and Long-Term Care**

   a) **develop and distribute educational resources to the public that provide guidelines and information about non-urgent care;**

   b) **track the number of patient visits to emergency departments for non-urgent care to assess the effectiveness of the educational campaign; and**

   c) **adjust, if necessary, and repeat the campaign until a satisfactory level of patient visits to emergency departments for non-urgent care is achieved and sustained.**

3. **The Ministry of Health and Long-Term Care**

   a) **establish ranges for average payments to physicians by medical specialty;**

   b) **regularly track and identify reasons when payments to physicians exceed the average payment within the same specialty; and**

   c) **obtain accurate information on physicians' practices, including operating costs and profit margins.**

4. **The Ministry of Health and Long-Term Care**

   a) **establish formal ranges for reporting the results of its payments to physicians to the public;**

   b) **regularly track and monitor the accuracy of physician billings and compare these to the ranges; and**

c) **ensure that inappropriate billings are recovered on a timely basis.**

5. **The Ministry of Health and Long-Term Care**

   a) **review the recommendations from the third-party report and provide the Committee with corresponding timelines for expected implementation dates;**

   b) **provide the Committee with its rationale for not implementing certain recommendations, if applicable; and**

   c) **provide the Committee with a copy of the third-party report.**

6. **The Ministry of Health and Long-Term Care provide the Committee with an update on the status of its billing review analysis and, if applicable, timelines for implementing changes.**