Ministry of Health and Long-Term Care

Physician Billing

Follow-Up on VFM Section 3.11, *2016 Annual Report*

RECOMMENDATION STATUS OVERVIEW						
	# of	Status of Actions Recommended				
	Actions Recommended	Fully Implemented	In Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	1		1			
Recommendation 2	3	1	1	1		
Recommendation 3	3		2	1		
Recommendation 4	1	1				
Recommendation 5	3			3		
Recommendation 6	1			1		
Recommendation 7	2			2		
Recommendation 8	2			2		
Recommendation 9	2	2				
Recommendation 10	4		1	3		
Recommendation 11	2		1	1		
Recommendation 12	3	1	1		1	
Recommendation 13	1		1			
Recommendation 14	1	1				
Total	**29**	**6**	**8**	**14**	**1**	**0**
%	**100**	**21**	**27**	**48**	**4**	**0**

Overall Conclusion

As of August 31, 2018, the Ministry of Health and Long-Term Care (Ministry) has fully implemented 21% of the actions we recommended in our *2016 Annual Report*. For example, Health Quality Ontario (HQO) has developed clearly defined indicators to measure quality of care for primary care patients. At the time of this follow-up, HQO had identified a total of 199 candidate primary care indicators and further prioritized 23 of them as key indicators.

The Ministry has made progress in implementing a further 27% of the recommended

actions. For instance, at the time of our follow-up the Ministry was evaluating capitation rates for both Family Health Organizations and Family Health Groups to ensure that the fees paid are justified for the basket of services physicians actually provide to their enrolled patients.

There has been little or no progress on 48% of the actions. For example, the Ministry has made no progress in obtaining accurate information on physicians' practices, including their operating costs and profit margins in providing Ontario Health Insurance Plan (OHIP) services.

The Ministry indicated it would not be implementing the remaining one action, recovering the $3.2 million of overpayments to physicians related to the cardiac rhythm monitoring tests that were inappropriately claimed, because the physicians involved ceased billing the Ministry in that manner. This prevented the Ministry from going to the Physician Payment Review Board.

The status of actions taken on each of our recommendations is described in the following sections.

Background

Physicians in Ontario operate as independent service providers and bill their services to the Province under the Ontario Health Insurance Plan (OHIP) as established under the *Health Insurance Act*.

As of March 31, 2017, Ontario had about 30,922 physicians—16,471 specialists and 14,451 family physicians (2016: 30,200 physicians—16,100 specialists and 14,100 family physicians)—providing health services to more than 13 million residents. The cost to the Province for the year then ended was $11.86 billion (2016: $11.59 billion).

Under the December 2012 Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution Agreement (OMA Representation Rights Agreement), the Ministry of Health and Long-Term Care (Ministry) recognized the OMA as the exclusive bargaining agent of physicians, and both parties agreed, among other things, to consult and negotiate in good faith on physician compensation and related accountability.

The Ministry is responsible for establishing policies and payment models to fairly compensate physicians, while at the same time ensuring that taxpayer funds are spent effectively.

Physicians in Ontario can bill under three major models:

- Fee-for-service model (fiscal year 2016/17: $6.52 billion [2015/16: $6.33 billion]) under which physicians are compensated based on a standard fee for each service they perform. They bill using fee codes in OHIP's Schedule of Benefits. This has been the principal billing model since 1972.
- Patient-enrolment model (fiscal year 2016/17: $3.41 billion [2015/16: $3.38 billion]) under which physicians form group practices (such as Family Health Organizations and Family Health Groups) and are paid for the number of patients enrolled with them, and for a predetermined basket of services the group provides to those patients. As of March 31, 2017, 9,001 out of 14,451 family physicians had opted for one of the patient-enrolment models.
- Alternative payment plans (fiscal year 2016/17: $1.93 billion [2015/16: $1.88 billion]) and other contracts with hospitals and physician groups to provide specific services. In addition to the $1.93 billion, approximately $1.3 billion was paid to alternative-payment-plan physicians as fee-for-service, which is included in the $6.52 billion paid under the fee-for-service model mentioned above.

Our audit found that in the five-year period prior to our 2016 audit, Ontario physicians had been among the highest paid in Canada. 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—a more expensive model than fee-for-service. For example, in 2014/15, family physicians in patient-enrolment models received incentive payments costing $364 million on top of the fixed payment paid for each enrolled patient, regardless of patient visits or services performed.

Other significant observations from our *2016 Annual Report* include the following:

- Patient-enrolment models for compensation of family physicians were not meeting original objectives and posed management issues for the Ministry.
  - The Ministry estimated that for the year ended March 31, 2015, physicians were paid for base capitation under Family Health Organizations approximately $522 million that would not have been paid under a fee-for-service model, in part because physicians were compensated for approximately 1.78 million patients that they had enrolled, but did not treat.
  - The Ministry's billing system indicated that 40% of enrolled patients went to walk-in clinics or other family physicians outside the group in which they were enrolled. As well, an estimated 27% of enrolled patients had chronic health conditions and regularly sought primary care outside their physician group, contrary to best practices. This resulted in duplicate payments of $76.3 million cumulatively over the five years up to fiscal 2014/15. The Ministry did not recover these payments.
  - During 2014/15, about 243,000 visits were made to emergency departments for conditions that could have been treated in a primary care setting. The Ministry estimated these visits cost $62 million, of which $33 million was incurred by patients enrolled in Family Health Organizations that are compensated using the patient-enrolment model. The Ministry did not recover this money from these patients' family physicians.
- The Ministry faced challenges controlling costs under the fee-for-service model. For example:
  - Fee-for-service claims had been growing at an annual rate of 3.3%, despite the Ministry's targeted rate of 1.25%. The Ministry had not been successful in achieving a reduction in payments for medically unnecessary services.
  - We noted that large variances existed in gross payment per physician (before deduction of office expenses and overhead) within certain specialties. However, the Ministry did not have complete information on physicians' practices and profit margins to help it analyze the disparities.
- The Ministry lacked a cost-effective enforcement mechanism to recover inappropriate payments from physicians. Its recovery process on inappropriate billings was lengthy and resource-intensive: the onus is on the Ministry to prove that the physicians who bill on the honour system are in the wrong, not on the physicians to prove they are entitled to the billing.
- The Ministry did not investigate many instances where physician billings exceeded the standard number of working days and expected number of services. We noted that, for example, nine specialists submitted claims indicating that each had provided services on more than 360 days in 2015/16. While the Ministry had initiated some investigations on its own, they were not done in a timely manner.
- Since the beginning of 2013, the Ministry had not actively pursued recovery of overpayments in proactive reviews; it was recovering approximately $19,700 in 2014 and nothing in 2013 and 2015. In prior years, recoveries were well over a million dollars.

- The Ministry no longer followed up on all physicians who had billed inappropriately in the past.
- The Ministry targeted savings of $43.7 million for 2013/14 by reducing the number of unnecessary preoperative cardiac tests, but actual savings were only $700,000.

The report contained 14 recommendations, consisting of 29 actions, to address our audit findings. We received commitment from the Ministry that it would take action to address our recommendations.

Standing Committee on Public Accounts

On March 29, 2017, the Standing Committee on Public Accounts (Committee) held a public hearing on our 2016 audit. In February 2018, the Committee tabled a report in the Legislature resulting from this hearing. The Committee endorsed our findings and recommendations, and made six additional recommendations. The Ministry reported back to the Committee in August 2018. The Committee's recommendations and our follow-up on its recommendations are found in **Chapter 3**, **Section 3.05** of this volume of our *2018 Annual Report*.

Status of Actions Taken on Recommendations

We conducted assurance work between April 2, 2018, and August 31, 2018, and obtained written representation from the Ministry of Health and Long-Term Care that, effective October 31, 2018, it has provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

Significant Investment in Patient-Enrolment Models but Most Objectives Not Met

Recommendation 1

To help ensure that patient-enrolment models are cost-effective, the Ministry of Health and Long-Term Care should review the base capitation payments and make any necessary adjustment in order to ensure that the fees paid are justified for the basket of services physicians actually provide to their enrolled patients.

Status: In the process of being implemented by March 2020.

Details

During our 2016 audit, we found that patient-enrolment models were significantly more expensive than the traditional fee-for-service model. The Ministry estimated that, in 2014/15, a family physician who belonged to a Family Health Organization earned an annual gross revenue of $420,600, and one who belonged to a Family Health Group earned an average of $352,300. Both of these average salaries were significantly higher than the gross billing of $237,100 physicians would earn, on average, under the traditional fee-for-service model. Yet, the base capitation payments that physicians receive before they actually see any of the patients they enroll were originally designed to be cost-neutral, or about the same as if the services were being provided on a fee-for-service basis.

Further, the Ministry estimated that for the year ended March 31, 2015, physicians in Family Health Organizations were paid base capitation of approximately $522 million that would not have been paid under a fee-for-service model, in part because physicians were compensated for approximately 1.78 million patients who were enrolled but did not visit their physicians in that year.

Following our 2016 audit, the Ministry initiated an evaluation of base capitation rates for both Family Health Organizations and Family Health Groups, which was ongoing at the time of this follow-up. The evaluation includes an analysis of services provided to patients based on demographics

such as age and sex, as well as an evaluation of how often each service in the basket of services covered under the patient-enrolment models is provided to enrolled patients.

The Ministry and the Ontario Medical Association (OMA) have been without a contract since the previous agreement expired on March 31, 2014. In May 2017, the two parties agreed to a Binding Arbitration Framework Agreement (arbitration). The three-person Arbitration Board consists of an arbitrator jointly selected by the Ministry and the OMA, a Ministry nominee, and an OMA nominee. Phase one of arbitration began in May 2018.

In June 2018, the parties agreed to return to negotiation in July in an attempt to reset the relationship and explore the possibility of reaching a mutually accepted settlement. Dates in July that had been scheduled for arbitration were used for negotiation instead, and further negotiation dates were added for August and September. The parties returned to arbitration in October and have hearings scheduled to December. Phase two of arbitration will follow.

The Ministry indicated that any adjustments to the base capitation payments would require it to engage with the OMA through the negotiation or arbitration process, which is expected to be completed by March 2020. The progression of negotiations is difficult to predict, and timelines for any return to arbitration are at the discretion of the Arbitration Board. The Ministry's target date of March 2020 is therefore an estimate.

Recommendation 2

To help ensure that patients receive better quality care that is cost effective and that patient-enrolment models for family physicians meet the goals and objectives of the Ministry of Health and Long-Term Care (Ministry), the Ministry should:

- *clearly define indicators to measure "quality of care" for enrolled patients;*
  Status: Fully implemented.

Details

During our 2016 audit, we found that although one of the Ministry's goals was to increase quality of care for patients of family physicians, it had not clearly defined that term for patient-enrolment models, and it has set no targets to measure quality.

In late 2015, Health Quality Ontario (HQO) launched primary care reporting on its webpages. At the time of this follow-up, through the Primary Care Performance Measurement Framework project, HQO had identified a total of 199 candidate primary care indicators and further prioritized 23 key indicators, including:

- percentage of patients who report that, in the past 12 months, they had a review and discussion with their primary care provider regarding prescription medications they are using;
- percentage of patients who see their primary care provider within seven days after discharge from hospital for selected conditions;
- percentage of total primary care visits that are made to the physician with whom the patient is enrolled; and
- percentage of patients with diabetes with two or more glycated hemoglobin (HbA1c) tests within the past 12 months.

In addition, family physicians can now register to receive HQO's MyPractice reports, which provide confidential information about their own practice in relation to peers across the province. The reports include indicators in the areas of opioid prescribing, cancer screening, diabetes management, and their patients' use of health services (for example, emergency department visits, hospital readmissions, and visits to their own physician). As of June 2018, over 2,700 family physicians had registered to receive MyPractice reports.

- *establish targets that the patient-enrolment models should achieve within a given period of time;*
  Status: Little or no progress.

Details

As mentioned, at the time of our 2016 audit, the Ministry had not set targets to measure the quality of care for patients of family physicians. In 2015, the Ministry developed a performance report that consolidated a number of statistics and performance metrics for each patient-enrolment model. The report was developed only for the 2014/15 fiscal year and did not include any benchmarks or standards against which reported metrics could be measured. Benchmarking against performance standards (or against the achievements of high-performing systems) helps establish performance targets and quantify the potential for improvement.

During our follow-up, the Ministry indicated that establishing targets for the patient-enrolment models would require its engagement with the OMA through negotiation or arbitration as discussed in **Recommendation 1**. However, we found that in preparing for arbitration, the Ministry had made little progress in determining potential targets and time frames for achieving them.

- *collect and publish relevant and reliable data to monitor and assess performance against targets on a regular basis.*
  Status: In the process of being implemented by March 2020.

Details

HQO publicly reports on its website 10 of the 23 key primary care indicators. The indicators cover the areas of access to primary care, illness prevention and detection, and health system co-ordination, with the data stratified according to, for example, age, sex, income, education level, and urban versus rural location. The 10 indicators reported on HQO's website are compared across the 14 Local Health Integration Networks within the province, and by year. The remaining 13 indicators are not publicly reported on due to the lack of a consistent data source or unsuitability for public reporting. However, many of these indicators are reported at the physician-practice level.

Neither the Ministry nor HQO had set performance targets for the 10 publicly reported primary care indicators. Instead, the Ministry and HQO compare these indicators with any available data from other jurisdictions and use year-to-year analysis to monitor any significant trends. Again, the Ministry indicated that establishing targets for the patient-enrolment models would require its engagement with the OMA through negotiation or arbitration, which is intended to be completed by March 2020.

Recommendation 3

To ensure patients are able to access their family physicians in a timely manner when needed, and also to reduce the strain on emergency departments in hospitals, the Ministry of Health and Long-Term Care should:

- *clearly define the minimum number of regular hours (including evening and weekend requirements) in every patient-enrolment contract;*
  Status: Little or no progress.

Details

Our 2016 audit reported that the base capitation payment had been set on the assumption that patient-enrolment physicians would keep regular office hours of sufficient length for their patients to see them for non-urgent care and not have to visit emergency departments. The Family Health Organization contract states that "except for Recognized Holidays, the physicians shall ensure that a sufficient number of physicians are available to provide the services during reasonable and regular office hours from Monday through Friday sufficient and convenient to serve Enrolled Patient." However, the terms "reasonable and regular" and "sufficient and convenient' were not defined in the contract. Patient-enrolment model contracts also did not stipulate the minimum number of services a physician or a group of physicians must perform over a given period.

In response to our follow-up, the Ministry indicated that further clarifying definitions of regular hours would require contract amendments, and so would require the Ministry to engage with the OMA through negotiation or arbitration as discussed in **Recommendation 1**. We found that in preparing for arbitration, the Ministry had made little progress in defining the potential minimum number of regular hours (including evening and weekend requirements) in every patient-enrolment contract.

- *regularly monitor and determine whether physicians participating in patient-enrolment models are meeting all their regular and after-hours requirements;*
- *implement consequences of not meeting contract requirements, such as the imposition of an administrative penalty/fine.*

  Status: In the process of being implemented by March 2020.

Details

Our 2016 audit found that many patient-enrolment family physicians did not work the number of weeknight or weekend hours required. We noted that, in 2014/15, 60% of Family Health Organizations and 36% of Family Health Groups did not meet their after-hours requirements. However, the Ministry took no action in such cases. In addition, patient-enrolment contracts have no financial penalties for not meeting after-hours requirements, even though the result could be patients visiting emergency departments or walk-in clinics, leading to duplication of taxpayer money for services already paid for and covered under the base capitation payments.

Since our 2016 audit, the Ministry has completed preliminary work on an improved accountability framework for physicians operating under an alternative payment plan such as a Family Health Organization or a Family Health Group. Part of this analysis includes a proposed performance management system that would monitor, among other things, whether physicians participating in enrolment models are meeting all their regular and after-hours requirements, and could include financial penalties for non-compliance.

At the time of our follow-up, the Ministry indicated that monitoring the hours of physicians participating in patient-enrolment models and implementing consequences for not meeting requirements would require engagement with the OMA through negotiation or arbitration, which is expected to be completed by March 2020.

Recommendation 4

To ensure that patients are able to receive continuity of primary care as stated in one of the Ministry of Health and Long-Term Care's (Ministry's) objectives, the Ministry should explore different options, such as requiring that patient records be shared between physicians, in order to better co-ordinate care for patients who continuously seek care from more than one primary care physician over time and implement change with the ultimate objective of putting the patient first.

Status: Fully implemented.

Details

Our 2016 audit noted that the Ministry intended that by having patients sign an enrolment form when they enrolled with a family physician, they would seek all their primary care from that physician. However, the Ministry's billing system indicated that in 2015, 40% of enrolled patients went to walk-in clinics or other family physicians outside the group in which they were enrolled. As well, the Ministry did not require physicians to share patients' records between clinics and physician practices. As a result, continuity of care was hampered, and services such as diagnostic testing may have been duplicated.

At the time of this follow-up, the Ministry had provided access to the province's two clinical viewers, ConnectingOntario and ClinicalConnect, to over 100 out of 857 primary care group practices in the province and 800 out of 2,739 primary care physician solo practitioners in the province. These clinical viewers are web-based portals that make

real-time access to patient digital health records available to physicians, and include information such as dispensed medications, laboratory results, hospital visits, home and community care services, mental health care information, diagnostic imaging reports and information from cancer programs.

The Ministry is working with Local Health Integration Networks to expand access to the provincial clinical viewers, and targets access for 80% of primary care providers by March 2022. The connectivity specifications have already been developed.

A pilot project that began in January 2016 is also underway that enables primary care physicians to share data through the clinical viewers. Four clinics are participating. Part of the pilot project is working to streamline use and collect lessons learned before a province-wide strategy can be developed. The Ministry expects to have a proposal for a provincial approach by March 2019.

Recommendation 5

To minimize the number of patient visits to emergency departments for non-urgent care that could be provided in a primary care setting, the Ministry of Health and Long-Term Care should:

- *evaluate whether the existing after-hours services offered by the contracted physicians are sufficient for their enrolled patients to obtain non-urgent care;*
- *better educate patients on the most appropriate place for non-urgent care when their family physicians are not available;*
- *consider best practices from other jurisdictions, such as for ensuring that after-hours care is easily accessible by patients within their local communities.*

Status: Little or no progress.

Details

In our 2016 audit, we found that during 2014/15, about 243,000 visits were made to emergency departments for conditions that could have been treated in a primary care setting. The Ministry estimated these visits cost $62 million, of which $33 million was incurred by patients enrolled in Family Health Organizations. The Ministry's survey for the period September 2014 to October 2015 reported that 42% of Ontarians (the same percentage as in 2013) indicated that the last time they visited an emergency department was for a condition that could have been treated by their primary care physician if he or she had been available.

Our follow-up found that the Ministry had made little progress on all three actions. Since our 2016 audit, the Ministry has not evaluated whether the existing after-hours services offered by the contracted physicians are sufficient for their enrolled patients to obtain non-urgent care and has not considered best practices from other jurisdictions specific to access to after-hours care. Although patient education (on the most appropriate place for non-urgent care when their family physicians are not available) does not require negotiation with the OMA, the Ministry indicated that it would consult with the OMA on patient education materials. The Ministry did not have any expected timeline for such consultation.

The Ministry again advised that any proposed changes for the first and third actions would require its engagement with the OMA through negotiation or arbitration as mentioned in **Recommendation 1**.

Physician Payments Vary Widely

Recommendation 6

To get a better understanding of the significant variations in physician compensation within and between specialties, the Ministry of Health and Long-Term Care should obtain accurate information on physicians' practices, including their operating cost and profit margin in providing OHIP services.

Status: Little or no progress.

Details

Our 2016 audit found that, even within the same specialty, there were large variances between the

median gross billing paid and the gross billing paid at the 90th percentile. We noted that in the five specialties with the largest variances in 2014/15, differences ranged from approximately $460,400 to $713,000. As well, we noted that average payments to physicians also differ significantly by medical specialty, and are due to the differences in the nature of their work and how they are paid. However, the Ministry did not have complete information on physicians' practices and profit margins to help it analyze the disparities.

Subsequent to our 2016 audit, the Ministry made little progress toward obtaining complete and accurate information on physician practices, including their operating cost and profit margin in providing OHIP services, to better understand the significant variations in physician compensation. The Ministry again indicated that following this recommendation would require its engagement with the OMA through negotiation or arbitration as mentioned in **Recommendation 1**. However, the Ministry had done minimal work to determine the relevant financial information and how it should be obtained from physician practices.

The Implementation of Patient-Enrolment Models Has Been Flawed

Recommendation 7

To ensure that the access bonus paid to encourage family physicians in patient-enrolment models has its intended effect, and that the bonus does not result in duplicate payments for some medical services, the Ministry of Health and Long-Term Care should:

- *implement the recommendations from its policy review on the access bonus to educate targeted physicians, improve reporting to physicians to help them better understand their patients' use of outside services, and improve patient education by making patients fully aware of the commitment they agree to when they enroll with their family physicians;*
- *redesign the bonus so that the Ministry does not pay for duplicated services.*

Status: Little or no progress.

Details

In our 2016 audit, we reported that in some cases, when patients visit physicians other than the one they are enrolled with, the Ministry pays twice for services already covered under enrolment-based payments: once through the capitation payments to the family physician practising under a patient-enrolment model, and again through the fee-for-service payment to the other physician (for example, a physician practising at a walk-in clinic). The result was duplicate payments of $76.3 million cumulatively over the five years leading up to fiscal 2014/15.

The Ministry's access bonus working group made a number of recommendations in May 2014; however, due to the Ministry's ongoing negotiations with the OMA, none of the report's recommendations had been implemented at the time of our audit.

Since our 2016 audit, the Ministry has made little progress on this recommendation. It has not implemented the recommendations from its May 2014 policy review on the access bonus or redesigned the bonus so that it does not pay for duplicated services. The Ministry again informed us that changes to the access bonus would require engagement with the OMA through negotiation or arbitration as discussed in **Recommendation 1**.

Recommendation 8

To better ensure that patient-enrolment models are cost-effective and that capitation payments, premiums and incentives achieve their intended purposes, the Ministry of Health and Long-Term Care should:

- *pay capitation payments, premiums and incentives only where justified with evidence;*
- *periodically review the number of patients who do not see the physician they are enrolled with,*

and assess whether continuing to pay physicians the full base capitation payments for these patients is reasonable.

Status: Little or no progress.

Details

Our 2016 audit noted that, in January 2014, the Ministry paid $40 million as an interim payment modifier to all patient-enrolment physicians who treated high-needs patients enrolled in their practices. Out of this $40 million, $17.4 million was paid to approximately 3,400 physicians who were in patient-enrolment models that are compensated on an enhanced fee-for-service basis—which indicates that these physicians were already being compensated for treating their high-needs patients. These 3,400 physicians therefore should not have received the payment. However, although the $17.4 million payment was not justified, the Ministry agreed to let the payment stand after its negotiations with the OMA in 2012.

In addition, our audit found that, in 2014/15, 1.78 million (or 33%) of the 5.4 million patients enrolled with a Family Health Organization did not visit their family physicians at all, yet we estimated that these physicians still received a total of $243 million just for having them enrolled.

We discuss the evaluation of base capitation rates that the Ministry undertook following our 2016 audit, and was ongoing at the time of this follow-up, in **Recommendation 1**. Subsequent to our audit, the Ministry has made little progress toward paying premiums and incentives only where it has evidence to justify that these payments achieve their intended purpose. It has also not demonstrated progress in starting to periodically review the number of patients who do not see the physician they are enrolled with, and in assessing whether continuing to pay physicians the full base capitation payments for these patients is reasonable. At the time of our follow-up, the Ministry indicated that any adjustments to base capitation payments, premiums and incentives continued to be subject to negotiations and/or its arbitration framework with the OMA, in that changes to these payments would require the Ministry to engage with the OMA through this process.

Oversight of Fee-for-Service Payments to Physicians Is Weak

Recommendation 9

To ensure that health-care dollars are spent only on procedures that are medically necessary, the Ministry of Health and Long-Term Care should work with the appropriate medical professionals to:

- *establish evidence-based standards and guidelines for each specialty to ensure all procedures and/or tests performed are medically necessary for patients;*

  Status: Fully implemented.

Details

Our 2016 audit noted that the Ministry had identified over 500 physicians who billed over $1 million each to OHIP in 2014/15, and had selected 12 of them for further analysis. The Ministry suspected that some of these billings may have been inappropriate: for instance, medically unnecessary services might have been performed or payment made for services that had not been rendered, or the standard of care might have been breached in other ways. In addition, our review of fiscal 2015/16 data found at least 648 specialists whose billing trends were anomalous when compared to the expected range of days billed and services by specialty category.

In September 2017, HQO launched the Ontario Quality Standards Committee, which is a sub-committee of the HQO Board of Directors with governance oversight of the Quality Standards Program (Program). The Program establishes quality standards for clinicians, organizations and the health system based on the best available evidence and consensus of an expert advisory committee. The Ministry and HQO have co-operated to prioritize topics for developing quality standards, focusing

primarily on areas where there is significant and unwarranted variation in clinical care.

At the time of our follow-up, the Program had finalized 14 quality standards and published them on HQO's website. The 14 standards cover a number of areas, including dementia, opioid prescription and addiction, hip fractures, and vaginal birth after Caesarean section. An additional 11 standards were listed as in development, such as chronic obstructive pulmonary disease, glaucoma, lower back pain and heart failure.

Each standard includes quality statements to inform health-care professionals and organizations what care to provide at which stages. The standards also include quality indicators to help health-care professionals and organizations with their improvement efforts, and recommendations on how to adopt the standards.

- *provide better education to patients on the common procedures that are not evidence-based.*
  Status: Fully implemented.

Details

Each quality standard developed by the Program includes a patient guide that is intended to help make patients, families and caregivers aware of what high-quality care looks like and ask health-care professionals informed questions. The patient guides were developed with input from patients and caregivers with experience in the topic area. Clinicians and health-care organizations are encouraged to let their patients know that the guides are available on the HQO website, so that patients can ask their health care providers informed questions about their care. The guides are also shared with relevant patient groups to share with their broad patient communities.

Where appropriate, patient guides advise patients when procedures they might seek are not evidence-based. For example, the draft patient guide for the osteoarthritis standard tells patients: "arthroscopy should not be used to treat knee osteoarthritis because it does not change the progression of osteoarthritis or improve people's quality of life."

Recommendation 10

To strengthen the oversight of fee-for-service payments to physicians to ensure that taxpayer dollars are fully recovered in situations of inappropriate billings, the Ministry of Health and Long-Term Care should:

- *evaluate the costs and benefits of amending the fee-for-service billing review process and re-establishing an inspector function to oversee physician billings;*
  Status: Little or no progress.

Details

In our 2016 report, we noted that, in 2005, the Ministry drastically changed the way it audits payments made to physicians. The change was in response to a report requested by the Government in 2004. Prior to 2005, the Ministry employed audit inspectors through the College of Physicians and Surgeons of Ontario, who could inspect medical records on-site, interview physicians, and make observations within their practices. Since then, the Ministry's audit process uses medical advisors rather than inspectors. Advisors can only review medical records off-site, after they receive copies of the records from the physicians. We noted that both British Columbia and Alberta conduct on-site inspections as part of their physician billing audits.

Since our 2016 audit, the Ministry has not evaluated the costs and benefits of amending the fee-for-service billing review process or re-establishing an inspector function. The Ministry indicated that implementing any changes to the billing review process would require legislative amendments to the *Health Insurance Act*.

- *effectively monitor billings and ensure physicians correct their inappropriate billings on a timely basis;*
  Status: In the process of being implemented by March 2020.

Details

Our 2016 audit reported that since the Ministry focuses its efforts on educating physicians whose

billings are inappropriate and instructing them to correct future billings, we expected that an ongoing monitoring process would be in place to ensure that physicians with problematic billing corrected further billings. However, we found that the Ministry did not follow up on all of these physicians.

We reported in 2016 that since the beginning of 2013, the Ministry had not actively pursued recovery of overpayments in proactive reviews; it was recovering approximately $19,700 from one physician in 2014 and nothing in 2013 and 2015. In prior years, recoveries were well over a million dollars.

Following our audit, the Ministry hired eight full-time staff in positions directly involved in physician billing oversight to conduct more reviews of potential inappropriate billings and follow-ups on physicians with problematic billing, as well as to settle more cases with physicians who voluntarily repay the Ministry for overpayments.

From 2016 to the time of our follow-up, the Ministry recovered or was in the process of recovering $819,950 from four physicians through proactive reviews. This represents a significant increase from the $19,700 recovered from 2013 to 2015, but is still far below the $1,837,000 recovered from 184 physicians in 2012 alone.

Reactive reviews and recoveries based on complaints received have increased significantly since our audit. Between 2016/17 and 2017/18, the Ministry completed 338 reactive reviews and recovered or was in the process of recovering $2,436,500 from 57 physicians. This compares favourably to the 260 reactive reviews between 2014/15 and 2015/16, which led to $501,400 in recoveries from 19 physicians.

The Ministry has obtained software to enable it to more effectively monitor, identify and interact with physicians on inappropriate payments.

The Ministry intends to brief the government and determine further steps to effectively monitor billings and ensure that physicians correct their inappropriate billings on a timely basis by March 2020.

- *establish an effective mechanism to recover overpayments from physicians when inappropriate billings are confirmed;*
  Status: Little or no progress.

Details

Our 2016 audit reported that the Ministry's recovery process on inappropriate physician billings was ineffective, lengthy and resource-intensive. Under this process, the onus is on the Ministry to prove that the physicians have billed contrary to the provisions of the *Health Services Act*. Unless a physician agrees to repay inappropriate payments voluntarily, it is very difficult to recover the payments. Current legislation restricts the Ministry from ordering a physician to repay an overpayment or requesting reimbursement for payment of claims billed contrary to provisions of the *Health Services Act* unless it has an order from the Physician Payment Review Board. We also found many instances when even though the Ministry had evidence to confirm that certain billings were not appropriate, it did not make an effort to recover overpayments from the physicians.

At the time of our follow-up, the Ministry is still following the same process. It explained that any changes to the recovery process will require legislative amendments to the *Health Insurance Act*.

- *streamline the existing review and education process for physician billing.*
  Status: Little or no progress.

Details

As mentioned, at the time of our follow-up, the Ministry was testing new software to more effectively monitor, identify and interact with physicians on inappropriate payments. As of June 2018, the Ministry indicated that implementation of the software was not complete. Further investment is required to fully implement the tool. Once it is implemented, the software will enhance the monitoring and data analysis needed to identify and track inappropriate payments and interact with physicians regarding them.

Since our 2016 audit, the Ministry has made little progress in streamlining the existing review and education process for physician billing. It explained that any changes to the review and education process would require legislative amendments to the *Health Insurance Act*.

Ministry Having Challenges Managing Health-Care Services Billed Under the Fee-for-Service Model

Recommendation 11

To ensure that the fees on the Schedule of Benefits reflect current medical practice and the needs of the health-care system, the Ministry of Health and Long-Term Care should:

- *re-establish the Medical Services Payment Committee to provide regular reviews of physicians' fees and evidence-based advice on fee revisions;*
  Status: In the process of being implemented by March 2020.

Details

In our 2016 audit, we noted that, as of December 31, 2015, the Ministry's most recent available data indicated that utilization for fee-for-service claims had been growing at an annual rate of 3.3%, which was higher than its yearly expenditure growth of 1.25%. Because of the difficulties the Ministry faced in containing costs under the fee-for-service model, it implemented across-the-board cuts in 2015. The across-the-board cuts were not evidence-based, and in some cases disproportionally impacted lower-earning physicians as opposed to higher-income physicians.

The *Health Insurance Act* requires that the Ministry establish a committee to recommend timely and appropriate revisions to the fee schedule and other payment programs, in line with current medical practice and the needs of the health-care system. The committee has the additional intent to bring fees into greater relative balance in accordance with innovation, access, integration and competitiveness. We noted at the time of our last audit that this committee, known as the Medical Services Payment Committee, had been inactive since the last agreement between the Ministry and the OMA expired on March 31, 2014.

Since our audit, the Ministry has been unable to re-establish this committee, as it is still in negotiation or arbitration with the OMA. The Ministry acknowledged the benefit of having a Ministry-OMA bilateral committee to make recommendations on amendments to the fee schedule and other payment programs, and advised that the terms of reference for such a committee will depend on the outcome of negotiation or arbitration as described in **Recommendation 1**.

- *assess the impacts that technological advancements have had on treatment times for consideration in adjusting fee-for-service codes.*
  Status: Little or no progress.

Details

Our 2016 audit noted that when technological advances let physicians deliver services more easily and quickly, the volume of services increases. For example, in 2006, cataract surgery took about an hour and the total fee was $516. At the time of our audit, technological advancement had made this surgery much easier to perform and had decreased the time required to only about 15 minutes. As part of the then Medical Services Payment Committee's review, the total fee was reduced to $442 in September 2011.

In response to our follow-up, the Ministry informed us that adjusting fee-for-service codes would require the engagement of the OMA through negotiation or arbitration as described in **Recommendation 1**. The Ministry had done no assessment of the impacts of technological advancement on treatment times at the time of our follow-up.

Ministry Has Recently Acted on the Significant Increase in Echocardiography Services Billed

Recommendation 12

To strengthen the oversight of the use of cardiac ultrasound services, the Ministry of Health and Long-Term Care should work with the Ontario Association of Cardiologists and the Cardiac Care Network of Ontario to:

- *assess the effectiveness of the Cardiac Care Network of Ontario's Echocardiography Quality Initiative program intended to deter inappropriate use of cardiac ultrasound services;*
  Status: In the process of being implemented by December 2019.

Details

During our 2016 audit, the Ontario Association of Cardiologists (Cardiologists Association) raised a concern over the appropriateness of some echocardiography (cardiac ultrasound tests). We noted that the Ministry did not know which facilities were following appropriate standards and which were not, and it would not know until the new Echocardiography Quality Initiative (EQI) program managed by the Cardiac Care Network of Ontario is proven to be effective in overseeing the facilities where the services are provided.

On June 22, 2017, the Cardiac Care Network of Ontario and the Ontario Stroke Network merged to become CorHealth. In the fall of 2016, before the merger, the Cardiac Care Network had begun conducting quality assessments of registered echocardiography facilities; CorHealth expects to complete the site visits by March 31, 2019. The Schedule of Benefits of Physician Services requires clinics to be accredited or working toward accreditation through the EQI program before they can be paid by OHIP for echocardiograph services. At the time of our follow-up, 1,061 sites had been accredited or were working toward accreditation. Of those, 175 had received a certificate certifying achievement of standards, 571 were working toward a certificate, and the remaining 295 were non-operational.

The rate of growth for echocardiography services has fallen from a yearly average of 4.52% between 2012/13 and 2015/16 to 1.67% for 2016/17 over 2015/16. Monitoring of the EQI program's impact on service volume is ongoing. The Ministry is targeting December 2019 to complete an assessment of the effectiveness of the program in deterring inappropriate cardiac ultrasound services. This allows the program nine months after completing site visits in March 2019 to meet with clinics to remedy any possible deficiencies.

- *monitor the use of cardiac ultrasound services claimed by facilities, such as those owned by non-physicians, and take corrective actions when anomalies are identified;*
  Status: Fully implemented.

Details

At the time of our 2016 audit, the Cardiologists Association questioned the Ministry's decision in 2015 to pay the same amount for cardiac ultrasound services regardless of whether a physician was on-site performing the test, or off-site but still available to supervise. The Cardiologists Association was concerned that this had boosted the profits of commercial lab facilities. However, in 2016 the Ministry had no complete information to test this claim. It did not know how many lab facilities existed and which were physician owned as opposed to commercial labs.

As mentioned, the Schedule of Benefits of Physician Services requires clinics to be accredited or working toward accreditation through the EQI program before they can be paid by OHIP for echocardiograph services (cardiac ultrasound tests). As part of the funding agreement, CorHealth reports every six months on the status and results of the program. CorHealth also provides the Ministry with updates on the status of clinics' accreditation with the program twice each month, and reports on clinics with critical concerns. The Ministry indicated

that as part of the accreditation process, at least seven clinics have narrowed the scope of the services they perform, and 10 clinics have voluntarily decided not to offer cardiac ultrasound services.

- *recover the $3.2 million of overpayments to physicians related to the cardiac rhythm monitoring tests that were inappropriately claimed.*
  Status: Will not be implemented. The position of the Office of the Auditor General is that the Ministry should explore all other avenues for recovery of the money.

Details

Our 2016 audit noted that, in October 2014, the Ministry became aware of fee-for-service claims related to two cardiac rhythm monitoring tests that were inappropriately claimed and paid to physicians. The Ministry determined that approximately 70 physicians were overpaid by at least $3.2 million between April 2012 and May 2015. However, at the time of our audit, the Ministry was not planning to directly recover any of the $3.2 million it had made in duplicate payments. It indicated that it does not have authority under the *Health Insurance Act* to directly recover the $3.2 million. Upon the Ministry's request, the company stopped billing in this manner, and under the *Health Services Act*, the Ministry cannot refer the matter to the Physician Payment Review Board.

The Ministry has informed us that the law pertaining to the process for recovery of inappropriate payments is still unchanged. The Ministry is currently reviewing legislation regarding the recovery of inappropriate claims. Also, the Ministry's follow-up review after our audit showed no evidence that the physicians were aware that their claims were inappropriate, and they stopped submitted claims in this manner. Further, it was unable to find evidence that the physicians knew or ought to have known that the claims were inappropriate, and therefore could not refer the claims to the Physician Payment Review Board for recovery.

Medical Liability Protection Costs Are Rising

Recommendation 13

To address the rising costs of medical liability protection, the Ministry of Health and Long-Term Care should work with the Canadian Medical Protective Association and the Ontario Medical Association to review the recommendations of the third-party report when it becomes available in early 2017, and take any necessary actions in an effort to reduce the cost burden on taxpayers.

Status: In the process of being implemented by March 2019.

Details

In our 2016 audit, we reported that physicians' medical liability costs in Ontario had risen dramatically—and they were continuing to rise. The Ministry and taxpayers had had to bear the responsibility for these significant cost increases. Our report also suggested that a joint effort by the Ministry, the OMA and the Canadian Medical Protective Association was long overdue to review the legal context surrounding the increase in medical malpractice trends.

In March 2016, the Ministry retained a third-party consultant to carry out a review and make recommendations on how to reduce medical liability protection costs, improve the efficiency of the civil system with respect to medical liability, and ensure that plaintiff-patients in medical malpractice cases receive appropriate compensation in a timely manner. The consultant requested an extension for delivery of its report, and it completed the report in December 2017, almost a year later than the original January 2017 due date. The report makes 40 recommendations, including:

- Consider whether a no-fault approach to medical liability cases should be explored.
- Learn from the experiences of leading American hospitals that have achieved dramatic reductions in medical mistakes.
- Devote increasing resources to risk-management initiatives and data sharing.

Due to the late release of the report, at the time of our follow-up, the Ministry was reviewing the recommendations and developing an appropriate implementation plan. It expects to brief the government on the implementation plan by March 2019.

Recommendation 14

To avoid being placed in a conflict of interest when investigating physicians' billings, the Ministry of Health and Long-Term Care should work with the Canadian Medical Protective Association and the Ontario Medical Association to ensure that taxpayer funds are not being used to reimburse physicians for membership fees due to the Canadian Medical Protective Association for the use of lawyers provided by the Canadian Medical Protective Association to assist physicians with Ministry billing reviews.

Status: Fully Implemented.

Details

In our 2016 audit, we noted that in some cases, when the Ministry reviews physicians' billings and asks the physicians to provide medical records to support and verify their claims, the physicians may request assistance from the Canadian Medical Protective Association in defending their billing practices, including legal support for most serious cases. As it is the Ministry that pays for the greater part of liability protection costs, we saw this as a potential conflict of interest, because the Ministry has a reduced incentive to investigate wrongdoing if it must pay a part of the physicians' legal costs.

On May 18, 2018, the Ministry requested written confirmation from the Canadian Medical Protective Association that the Ministry's subsidy excludes amounts associated with defending fee disputes between a physician and the government or criminal matters involving a physician. In July 2018, the Canadian Medical Protective Association responded to the Ministry's letter and indicated that billing and criminal matters represent a small percentage of overall medical liability protection costs and that the amount of funds that the Canadian Medical Protective Association expends annually on billing and criminal matters is significantly lower than the non-reimbursed portion of physicians' membership fees in Ontario. Based on the response received from the Canadian Medical Protective Association, the risk of the Ministry being placed in a conflict-of-interest situation appears to be low; therefore, no further action is required.