Office of the Auditor General of Ontario
Bureau de la vérificatrice générale de l'Ontario

Physician Billing

2016 Value-for-Money Audit

Why We Did This Audit

- Health-care costs will continue to increase as Ontario's population grows and ages. Payments to Ontario physicians in 2015/16 were $11.6 billion (2009/10 – $9.64 billion), accounting for 23% of Ontario's total health-care spending. Over the last five years, Ontario physicians have been among the highest paid in Canada.
- Physicians operate as independent service providers and are not government employees. They enroll patients and/or bill their services to the Province under the Ontario Health Insurance Plan (OHIP) as established under the *Health Insurance Act*. As of March 31, 2016, there were about 30,200 physicians (family physicians – 14,100; specialists – 16,100) in Ontario actively billing OHIP.
- The Ministry of Health and Long-Term Care (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.

Why It Matters

- It is important that physician payment models used by the Province are continually reviewed and updated to ensure that they provide physician compensation in a way that maximizes the benefit to those seeking health-care services, while fairly compensating physicians. As well, it is equally important that the Ministry ensures that payments are only provided for agreed-upon services rendered to ensure taxpayer value for money.

What We Found

The Ministry pays physicians mostly through a fee-for-service model, or a patient-enrolment model (for a predetermined basket of services with base capitation payments) or a combination of both.

Patent Enrolment Model

- Based on the Ministry's 2014/15 patient survey, patients are generally satisfied with their family physician.
- The Province paid physicians for base capitation under Family Health Organizations (the most popular patient-enrolment model) about $522 million more than it would have using the traditional fee-for-service model, in part because physicians were compensated an estimated $243 million for approximately 1.78 million patients that they had enrolled, but did not treat.
- Ontarians having a family physician increased by 43% between 2006/07 and 2015/16, from 7.4 million to 10.6 million. But 57% of Ontarians reported having to wait two or more days to see their family physician in 2015/16; more than the 51% reported in 2006/07.
- In 2014/15, each physician in a group practice called a Family Health Organization worked an average of 3.4 days per week, while each physician in a group practice called a Family Health Group worked an average of four days per week. As well, in the same year, 60% of Family Health Organizations and 36% of Family Health Groups did not work the number of weeknight or weekend hours required by the Ministry.
- About 40% of enrolled patients used walk-in clinics or other family physicians outside the group in which they were enrolled, and an estimated 27% of enrolled patients have chronic health conditions and regularly seek primary care outside their physician group. This led to duplicate payments totaling $76.3 million over the five years up to fiscal 2014/15, yet the Ministry does not recover these payments. Physicians are not required to share patients' records between walk-in clinics and family physician practices.
- Ministry survey data 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. During 2014/15, about 243,000 visits were made to emergency departments for conditions that could have been treated by family physicians. The Ministry estimated that these visits cost $62 million, of which $33 million was incurred for patients already enrolled in Family Health Organizations. The Ministry does not recover this money from these patients' family physicians.

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Fee for Service

- Fee-for-service claims have been growing at an annual rate of 3.3%, despite the Ministry's targeted rate of 1.25%. The Ministry has not been successful in achieving a reduction of medically unnecessary services. It initiated an across-the-board payment reduction because it did not reach an agreement with the OMA on future billing amounts and rules.
- The Ministry does not have the information it needs to assess whether the large variances in gross payment per physician (before deduction of office expenses and overhead) within certain specialties are reasonable. In 2014/15, ophthalmologists at the higher end of the pay range received an average of about $1.27 million each—close to 130% higher than the approximately $553,000 received by ophthalmologists in the middle of the pay range.
- There is a high disparity of gross payment per physician between different specialties. The fee-for-service model in Ontario favours procedural specialists (those who perform procedures such as diagnostic testing or surgery), who also generate a high volume of services. For example, vascular surgeons, who perform on average 12,230 services per year, would be paid an average of $43 per service, whereas pediatricians average 6,810 services and would be paid an average of $31 per service.
- The Ministry had minimal success in controlling excessive preoperative cardiac testing. It 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.

Billing Oversight and Enforcement Weak

- The Ministry lacks a cost-effective enforcement mechanism to recover inappropriate payments made to physicians. The Ministry has had no inspector function since 2005, and its current recovery process on inappropriate billings is lengthy and resource-intensive.
  - The Ministry does not investigate many anomalous billings, including a number of instances where physician billings exceed the standard numbers of working days and expected number of services. For example, nine specialists each worked over 360 days in 2015/16; six of these worked 366 days (2016 was a leap year).
  - The Ministry does not follow up on many cases of possible inappropriate billings by physicians. Since the beginning of 2013, the Ministry has not actively pursued recovery of overpayments in proactive reviews; it recovered nothing in 2013, about $19,700 in 2014, and nothing in 2015. We identified about 370 specialists who billed inappropriately for specific services and estimated that, between April 1, 2012, and March 31, 2016, the overpayment amounted to approximately $2.44 million.
  - We determined that the concerns of the Ontario Association of Cardiologists about cardiac-care spending, published in an open letter to the Auditor General, were reasonable. Although the Ministry determined that approximately 70 physicians were overpaid by at least $3.2 million between April 2012 and May 2015, the Ministry was not planning to recover any of this money at the time of our audit.

Physician Medical Liability Protection Costs Increasing

- Taxpayers continue to pay significant amounts for the rising cost of physician medical liability protection (2013 – $144.9 million; 2016 - $329.3 million). A joint effort between the Ministry, the Ontario Medical Association and the Canadian Medical Protective Association to review the legal context surrounding the dramatic increase in medical malpractice trends is long overdue.

Conclusions

- The government invested heavily in patient-enrolment models, giving the majority of Ontarians a family physician. However, the incremental cost of patient-enrolment models has not always led to more timely access to a family physician. Enrolled patients are still visiting walk-ins, other physicians and hospital emergency rooms for services treatable by their family physician.
- The Ministry is not able to demonstrate whether the more expensive patient-enrolment models have improved quality and continuity of care.
- The Ministry focuses its efforts on educating physicians on how to bill appropriately under the fee-for-service model rather than on improving oversight and pursuing recovery of inappropriate payments made to physicians.