# Outside Use is being used as a Red Herring to get Doctors to FUND Medical Care

The MOH has been stepping up its efforts to reduce outside use. There appears to be blind belief, just before the kool-aid is drunk, that if outside use were to be reduced, the MOH will save gazillions of dollars. The MOH proposes (see Section G: MOH Position Paper) "…*to recover negative access bonus payments dollar for dollar*". I'm sure the MOH staff are already familiar with what I am going to describe here and so, the fact that outside usage would never work perfectly, except maybe in a one-FHO small, isolated village, and the MHO want to "recover" outside bonus dollar for dollar tells me that they are using negative outside use as a red herring for a carefully planned money grab.

To reduce negative outside use MOH staff are actually instructing clinics (personal communication) to de-roster patients who are deemed "frequent flyers", without informing the patient. (I've never heard of any MOH department approve doing anything to a patient without a triplicate signed sworn affidavit, but apparently this is now ok). The MOH wants us to de-roster those who are rostered to one doctor but receive all or most care from another, non-affiliated doctor, especially the heavy users. Logical. Why pay a second doctor for services rendered when the MOH is also paying the rostering MRP? The problem lies in not fully understanding what happens in reality.

I've seen the analysis of one clinic's outside use history and in this case, which may not apply to others, the heavy users of outside services were patients seeking services at methadone clinics, those using pain clinics, and those being treated by a focused specialty such as psychotherapy. And the cost for these services tended to climb over $3,000 per patient annually (not including an ED visits); most of them young men and women (20-35 y.o.). If we were to play with these numbers we should be able to get a sense of what the MOH can expect to save, just by dealing with these heavy users. To simplify calculations let's assume 100 patients are heavy users and are about 30 years old and to increase the amount the MOH would save, let's assume they are more female patients (60) than male patient (40) (female patients cost more in roster).

| Annual Cost to MOH for Paying Outside Use + Roster Fees | | | | |
|---|---|---|---|---|
| # heavy users | Gender | Annual Cost of outside use (FFS) | Annual Cost of Roster | Total |
| 60 | F | $ 3,000 | $ 175 | $ 190,505 |
| 40 | M | $ 3,000 | $ 97 | $ 123,864 |

| | |
|---|---|
| Grand Total Costs | $ 314,369 |

In a calendar year these 100 patients would cost about $ 314,000. But, $300,000 would be incurred through OUTSIDE USE. It would appear that eliminating or reducing the outside use would certainly save a lot of money.

Outside use could be changed two ways: 1. The MRP provides all the services so that the cost would be reduced to $59,369 (i.e., 15% of 300,000=45,000 (shadow billing) +14,369 for roster fees) or 2. The MRP de-rosters the heavy users, which is the practical solution, for 2 reasons a) the MRP has little sway on where patients seek help, b) these heavy users require specialized services that the MRP is not qualified to give.

So what happens when the MRP de-rosters the patients?

| Annual Cost to MOH AFTER patients are de-rostered | | | | |
|---|---|---|---|---|
| # heavy users | Gender | Annual Cost of outside use (FFS) | Annual Cost of Roster | Total |
| 60 | F | $ 3,000 | $ - | $ 180,000 |
| 40 | M | $ 3,000 | $ - | $ 120,000 |

| | |
|---|---|
| Grand Total Costs | $ 300,000 |

| | |
|---|---|
| Total Savings | $ 14,369 |

The prudent physician, knowing they can't control (nor do they wish to) where patients get their medical care will simply de-roster heavy outside users if the MOH forces their position unilaterally. In this scenario, the MOH saves $14,369, not exactly the windfall $300,000 they were expecting. A mere $144 per patient. Technically, the MOH could try to collect all of the $300,000 deemed to be outside use. There is no reasonable cutoff as in "up to the total roster

payments". No. All of it. In effect, the MOH is hoping the doctors will pay for medicine in Ontario.

But in doing so they create another mess. MDs would be saddled with massive overhead in just trying to minimize the clawbacks by continually de-rostering patients who use methadone clinics, pain clinics, those who use psychoanalysis, and those who find it hard to always travel to their MRP's office. In effect, the more needy patients in the community would have to be orphaned; totally contrary to the MOH's own goals of reducing the number of orphaned patients, totally contrary to any ethical discussion about patient care.

Doctors would now be faced with the prospect of informing some patients that they are no longer registered at the clinic, and possibly not be served there (see Section L, below). De-rostering and still serving them would not be easily done in this new environment for 2 reasons: 1. Remuneration for serving patients rostered elsewhere (which could be the case for these de-rostered patients) would be only 75% of an amount that has not been increased for too many years to count. We're talking about rates not seen in more than 15 years! 2. In addition, with more of an MRP's patients forcibly de-rostered, there would be more close encounters with the FHO's cap for serving outside patients, also putting pressure of the doctor to not serve un-rostered patients. What a system we're designing!

At the end of the day, most outside use is generated by patients, not physicians. So to penalize the physicians is simply wrong, well, it's a red herring, trying to keep us off the true reason, another cash grab.