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## **Family Health Teams**

*Advancing Family Health Care*

# Guide to Physician Compensation

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## Purpose

This guide provides information to Family Health Teams on family physician compensation options. It is not meant to reflect an exhaustive review of the details of the compensation models, but rather is intended to provide general information on compensation choices, and how to obtain additional information.

This guide is one in a series developed to assist those in the process of forming Family Health Teams.

General information on Family Health Teams can be obtained from your Ministry of Health and Long-Term Care (ministry) contact or the ministry's website <http://www.health.gov.on.ca/familyhealthteams>.

## Background

The family physician/patient relationship is at the core of the primary health care delivery system. Family physicians are key members of Family Health Teams.

As stated in the 2004 *Memorandum of Agreement* between the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA), Section 5.2:

“The Parties understand that a relationship between a patient and his/her Family Physician has been a historic foundation in the delivery of primary care and continues to be pivotal in today's collaborative network of care providers. For this reason the Parties agree that every person should have the opportunity to enter into a relationship with a family physician who commits to the ongoing provision of primary care to that person. Enrolment reinforces the mutual commitment inherent in this relationship.”

Over the last several years, the ministry and the OMA have worked cooperatively to develop a menu of innovative and attractive compensation models that are aimed at rewarding family physicians for providing comprehensive primary health care services to their patients. These models will meet most of the needs of Family Health Team physicians and are described below in the section entitled Family Physician Compensation Models.

## The Role of Family Physicians in the Family Health Team

Family Health Teams provide a core set of comprehensive primary health care services to their patients. Patients can be enrolled either to an individual family physician or to groups of physicians. For more information on enrolment please refer to the *Guide to Patient Enrolment*.

The services to be provided in each Family Health Team will vary depending upon the needs of the population served and the size and composition of the provider team. All Family Health Teams will provide primary health care services that include: health assessments, diagnosis and treatment, primary reproductive care, primary mental health care, primary palliative care, patient education and preventive care, and Telephone Health Advisory Service (THAS). The service requirements are appended to this guide as Attachment A. In addition, some Family Health Teams may provide specialist services, diagnostic services and/or health promotion programs, chronic disease management, and rehabilitation services.

An individual Family Health Team may not be able to provide all services noted above but rather will facilitate appropriate service coordination and system navigation for the patient population and the community being served. This flexibility respects unique variations in local care arrangements, provider skills and population needs.

It is recognized and expected that the role of the family physician in a Family Health Team will vary depending upon the composition of the professional team and strategic community partnerships. For additional information, please consult with your ministry contact who will assist you.

## Working as Part of an Interdisciplinary Family Health Team

One of the unique features of Family Health Teams is the opportunity to work as part of an interdisciplinary team. For most teams this will include nurses, nurse practitioners and pharmacists. In some teams the group could include mental health workers, social workers, dietitians or other providers, depending upon the health needs of the population being served.

Access to services by patients may be enhanced by offering a variety of health care providers. The scope of services offered to patients can also be expanded through specialized programs.

The ministry has established guidelines and compensation options for these providers. This information can be found in the Family Health Team *Guide to Interdisciplinary Provider Compensation*.

## Primary Health Care Services and Incentives

In addition to listing comprehensive care services and existing incentives, this guide also includes new incentives included in the 2004 *Memorandum of Agreement* between the ministry and the OMA.

### *Comprehensive Care*

All Family Health Team physicians must provide comprehensive care services listed in Attachment A.

### *Health Promotion and Disease Prevention*

Physicians participating in Family Health Teams are entitled to receive incentives for smoking cessation and chronic disease management, as specified in Attachment B.

### *Specific Service Care Incentives and Premiums*

Physicians participating in Family Health Teams are also eligible for special premiums and enrolment fees, Continuing Medical Education (CME), etc. These incentives and premiums are specified in Attachment C.

### *Lead Physician Payments*

It is likely that one or more physicians will be asked to take on leadership duties and responsibilities, such as organizing the team, recruiting staff, setting clinical care guidelines, and quality assurance. For specific payment rates for each of the models, please call your ministry contact.

## Family Physician Compensation Models

Family physicians in Family Health Teams will be compensated via one of the following funding models:

- Blended Capitation Models: Family Health Networks (FHN) or Family Health Organizations (FHO);
- Blended Complement Model: Rural and Northern Physician Group Agreements (RNPGA); or
- Blended Salary Model (BSM).

All of the models encourage the delivery of comprehensive primary health care to patients by offering physicians the ability to earn incentives, premiums and special payments in addition to their capitation/complement payment or salaries for providing targeted services.

## 1. Blended Capitation Models

Blended Capitation Models provide a base payment per patient for the provision of comprehensive care plus incentives, premiums and special payments for the provision of specific primary health care services.

The FHN and FHO models are very similar with the exception of differences in the size of their basket of services, which is reflected in variations in the Base Rate Payment. The physician's enrolment population multiplied by the capitation rate, which is age and sex adjusted, are used to calculate the Base Rate Payment and calculation of the Access Bonus. The Access Bonus is a payment to blended capitation groups for providing core services exclusively to their enrolled patients.

Income stabilization is also available for Blended Capitation Model physicians who are new graduates (have graduated within the past three years) or who have never been signatories to a primary care model before. For details on this compensation mechanism, please consult with your ministry contact.

For further details, see Attachment D in this guide and the respective fact sheets at: <http://www.health.gov.on.ca/>.

## 2. Blended Complement Model

The Blended Complement Model provides compensation based on the number of physicians with the group. The model offers a base remuneration for the provision of comprehensive care, plus incentives, premiums and special payments for the provision of specific primary health care services, and funding for emergency services coverage. The Rural and Northern Physician Group Agreement (RNPGA) is currently one template that is funded under the blended complement model. This compensation model is available to identified communities with an underserved designation and a complement of 1–7 physicians, and is an amalgamation of the former Northern Group Funding Plans (3–7 physician communities) and Community Sponsored Contracts (1–2 physician communities). Under the amalgamated agreement, both types of contracts now come under the heading of RNPG agreements.

This compensation model provides funding on the basis of a commitment by the physician group to provide, coordinate or oversee the core primary health care services to all residents of a defined geographic area.

For additional detail on this compensation option refer to Attachment E, and the respective fact sheet at <http://www.health.gov.on.ca/>.

## 3. Blended Salary Model

The Blended Salary Model provides a base salary for the provision of comprehensive care, plus incentives, premiums and special payments for the provision of specific primary health care services. Funding is provided directly to the Family Health Team for the BSM physician's benefits and overhead.

Physicians with a roster fewer than 1,300 patients are considered to be part-time and, as such, their base salary will be pro-rated accordingly on a per-patient basis proportional to blended salary Level 1.

For information on salary, benefits, part-time and other compensation details see Attachment F and the respective fact sheet at <http://www.health.gov.on.ca/>.

## Income Stabilization for Blended Salary Model Physicians

Income stabilization is a program available to eligible physicians who wish to be compensated under the Blended Salary Model, as they develop patient rosters as part of a Family Health Team. Income stabilization funding is available for a period of up to 12 months, at which time the physician is required to transition to the Blended Salary Model<sup>1</sup>.

Income stabilization is available to physicians who wish to join the Blended Salary Model in exchange for full-time service and a commitment to enrol patients within the Family Health Team.

Physicians may also choose to be compensated on a part-time basis in the Blended Salary Model Income Stabilization Program, at a minimum service commitment of one day per week to the Family Health Team. The physician's income stabilization payment will be pro-rated based upon their FTE status, and will be proportional to the full-time income stabilization entitlement, using 40 hours as the determinant for full-time. Enrolment targets for part-time physicians will also be proportional to the full-time equivalency requirements.

For information on income stabilization for the Blended Salary Model see Attachment F and the respective fact sheet at <http://www.health.gov.on.ca/>.

## Locum Coverage

Locum and temporary physician absence coverage is available in all the family physician compensation models outlined above. The OMA also offers programs such as the Pregnancy/Parental Leave Benefit Program, which provides physicians with a pregnancy leave benefit of nine (9) consecutive weeks and a separate parental leave benefit of eight (8) consecutive weeks. The former OMAPs program now resides with Health Force Ontario Marketing and Recruitment Agency (HFO MRA), which offers rural physicians funding for coverage during vacation and other short-term leaves. For more information on these programs, and on locum provisions specific to each compensation model, please call your ministry contact.

## Payment for Overhead Expenses

The ministry will provide funding for each Family Health Team to recognize related operational overhead expenses for Blended Salary Model physicians, interdisciplinary health care providers, and administrators. This amount will vary based on the interdisciplinary team members employed.

Overhead is already included in the blended capitation and/or blended complement compensation models. Physicians compensated by these models are expected to continue to pay for overhead exclusively used by them.

Physicians paid by the blended capitation and blended complement models are eligible for the Office Practice Administration grant to support physician groups of five or more in their group to hire an administrator. For more information on this grant, please call your ministry contact.

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<sup>1</sup> See Attachment F for details on roster levels.

## Focused Practice General Practitioner Services

In some cases, general practitioners have unique areas of practice and care. These may include, among others, psychotherapy/mental health, palliative care, obstetrics and maternal care, or care of the elderly. Currently, only billings from general practitioners with an identified focused practice in psychotherapy will not impact access bonuses of physicians in Blended Capitation Models.

In addition, the ministry and the OMA will develop alternative funding plans for physicians dedicated to palliative care, care of the elderly, HIV, and oncology. In these instances, the group should consult with their ministry contact to discuss possible options and alternatives.

## Sessional Compensation Plan for Specialists

Medical specialists can enhance patient care through the provision of clinical<sup>2</sup> and/or indirect<sup>3</sup> services while visiting a Family Health Team. Eligible medical specialties include geriatrics, internal medicine<sup>4</sup>, paediatrics, and psychiatry (see Table 1).

Specialists are eligible under this plan if they:

- Provide clinical and/or indirect services *at* the Family Health Team site(s);
- Hold a certificate of registration from the College of Physicians and Surgeons of Ontario;
- Hold a certification number from the Royal College of Physicians and Surgeons of Canada;
- Hold an Ontario Health Insurance Plan (OHIP) physician billing number (123456);
- Have specialist physician designation in the Corporate Provider Database (CPDB); and
- Are insured for physician liability under the Canadian Medical Protective Association.

Family Health Teams are eligible for specialist services under this plan if they:

- Demonstrate a need for these clinical and/or indirect services in their Family Health Team;
- Demonstrate that clinical and indirect specialist services cannot be provided via Telemedicine; and
- Do not qualify for existing Ministry of Health and Long-Term Care specialist sessional programs (e.g. Underserviced Area Program, Visiting Specialist Clinic Program).

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<sup>2</sup> Clinical Services are directly related to the provision of health care. These include consultation, assessment, diagnosis, therapy and treatment of disorders, and others.

<sup>3</sup> Indirect Services are services not directly related to the provision of health care and include participation in case conferences, consultation with family physicians and interdisciplinary health care professionals, program support and development of program direction, provision of educational services for the team and for patients, system coordination, and resident and medical student supervision.

<sup>4</sup> Internal medicine includes neurology, endocrinology, respiratory medicine and rheumatology.

**Table 1: An overview of the *Family Health Team Sessional Plan for Specialists***

Specialty	Sessional Stipend <sup>5</sup>	Comptrollership Mechanism	Services Rendered	Incidental Expenses <sup>6</sup>
Psychiatry	\$429	Shadow Billing (10% premium, up to \$100 per session)	Clinical and indirect services	Funded via annual operating overhead allocated to the Family Health Team
Internal Medicine	\$575			
Paediatrics/Geriatrics	\$429			

## New Family Physicians

New family physicians (within 3 years of graduation) are eligible to claim a New Graduate-New Patient Fee.

In addition, Income Stabilization is available for new graduate physicians who are joining a Family Health Team where they are compensated using the Blended Capitation Models or the Blended Salary Model.

Please refer to Attachment C for information on the New Graduate-New Patient Fee (Q033A). For specific information and conditions associated with these payments, please consult with your ministry contact.

## Where to Get More Information

All potential Family Health Teams who have received conditional approval to proceed to the Formative Stage will be assigned a ministry contact. This ministry contact will be your guide to assist you to work through the details and options of establishing a Family Health Team.

If you have not yet been assigned a ministry contact, please refer to the ministry's website at: <http://www.health.gov.on.ca/familyhealthteams> for contact information.

<sup>5</sup> Stipends are for 3-hour sessions.

<sup>6</sup> Incidental Expenses include accommodation, travel expenses, parking, meals, long distance phone charges, and other out-of-pocket expenses.

## Attachment A – Family Health Team Comprehensive Care

Comprehensive Care assumes that the care is part of an on-going process into the future and provides care in the patient's family and social context. It includes the creation, management and maintenance of an appropriate medical record managed by the physician.

Family Health Team physicians must provide the following core services:

### **Health Assessments**

1. When necessary, the taking of a full history, including presenting complaint, if any, past illnesses, social history, family history, review of systems, and performing a complete physical examination;
2. Periodically taking a specific history and performing a physical examination as required to screen patients for disease; and
3. Regularly taking a specific history and performing a physical examination as required to respond to patient complaints and/or to manage chronic problems.

### **Diagnosis and Treatment**

Assess and plan for patients' care based on the outcomes of a history and physical examination aided by appropriate investigations and consultations according to the results of complete, periodic or regular health assessments. Care for and monitor episodic and chronic illness or injury. In the case of acute illness or injury, offer early access to assessment, appropriate diagnostic testing, primary medical treatment, and advice on self-care and prevention. Provide or coordinate chronic disease management for conditions such as diabetes and hypertension.

### **Primary Reproductive Care**

Provide primary reproductive care, including counselling patients on birth control and family planning, and educating about screening for and treating sexually transmitted diseases.

### **Primary Mental Health Care**

Offer treatment of emotional and psychiatric problems to the extent that the physician is comfortably able to provide the treatment. Where appropriate, refer patients to and collaborate with psychiatrists and appropriate mental health care providers.

### **Primary Palliative Care**

Provide palliative care or offer to support the team responsible for providing palliative care to the physician's terminally ill patients. Palliative care includes offering office-based services, referrals to Community Care Access Centres or to such other support services as are required, and making patient visits where appropriate.

### **Support for Hospital, Home and Long-Term Care Homes**

Where applicable and where possible, assist with discharge planning, rehabilitation services, outpatient follow-up and home-care services.

**Service Coordination and Referral**

Coordinate referrals to other health care providers and agencies, including specialists, rehabilitation and physiotherapy services, home care and hospice programs, and diagnostic services, as appropriate.

Appropriately monitor the status of patients who have been referred for additional care and collaborate on medical treatment of patients.

**Patient Education and Preventative Care**

Use evidence-based guidelines to screen patients at risk for disease, to attempt early detection and institute early intervention and counselling to reduce risk or development of harm from disease, including appropriate immunizations and periodic health assessments.

**Pre-Natal, Obstetrical, Post-Natal and In-Hospital New Born Care**

Provide or arrange to provide maternity services, including antenatal care to term, labour and delivery, and maternal and newborn care. If physicians do not offer full maternal care, they shall make best efforts to arrange for enrolled patients to receive these services.

**Arrangements for 24/7 Response**

Provide service to patients through a combination of regular office hours, extended office hours and the Telephone Health Advisory Service (THAS), which allows twenty-four hours a day, seven days a week response to patient health concerns.

**Professional Rights and Obligations**

Nothing in the agreement between the ministry and the Family Health Team precludes a physician from terminating a relationship with any patient in accordance with applicable guidelines issued by the College of Physicians and Surgeons of Ontario. Further, nothing in the agreement shall create obligations for a physician to go beyond his or her professional competence or that, using the physician's best efforts, go beyond the reasonable control of the physician.

## Attachment B – Health Promotion and Disease Prevention

Family physicians in Family Health Teams are eligible for the health promotion and disease prevention incentives listed in this section.

### **Smoking Cessation**

#### **Add-on Initial Smoking Cessation and Smoking Cessation Counselling Fees**

Physicians are entitled to receive an annual incentive of \$15.40 (fee code K079A) added on the normal visit fee for dialogue with enrolled patients who smoke. In addition, physicians are eligible to bill Q042A in conjunction with K039A to a maximum of two follow-up counselling sessions in the 365 day period following the service date of a valid Q041A for each patient who has committed to quit smoking.

### **Service Enhancement Codes**

Each physician may submit claims for the following Service Enhancement Codes pursuant to the terms set out below. All references to an enrolled patient are intended to include an enrolled patient's parent or guardian where appropriate.

#### **Preventive Care Management Service Enhancement Codes**

Subject to specified conditions, a Service Enhancement Fee of \$6.86 is payable to physicians for each enrolled patient he or she contacts for the purpose of scheduling an appointment for one of the following Preventive Care Management tests/procedures:

##### *Pap smear: Q001A*

The Service Enhancement Fee may be claimed biennially for each enrolled patient, between 35 and 70 years of age and at risk of cervical cancer, who is contacted for the purpose of scheduling a Pap smear.

##### *Mammogram: Q002A*

The Service Enhancement Fee may be claimed biennially for each female enrolled patient, between 50 and 70 years of age and at risk of breast cancer, who is contacted for the purpose of scheduling a mammogram.

##### *Influenza Vaccine for Enrolled Patients over 65: Q003A*

The Service Enhancement Fee may be claimed annually for each enrolled patient, over the age of 65, who is contacted for the purpose of scheduling an influenza vaccination.

##### *Immunizations for Enrolled Members under Two Years: Q004A*

The Service Enhancement Fee may be claimed once for each enrolled patient, between 18 months and 30 months of age, whose parent or guardian is contacted for the purpose of scheduling an appointment for ministry supplied immunizations pursuant to the guidelines set by the National Advisory Committee on Immunization.

##### *Colorectal Screening: Q005A*

This Service Enhancement Fee may be claimed annually for each enrolled patient, between 50 and 74 years of age (inclusive), at risk of colorectal cancer and who is not excluded from the target population, who is contacted for the purpose of scheduling a fecal occult blood test.

##### *FOBT Distribution and Counselling Fee: Q150A*

Effective April 1, 2008, the Q150A seven dollar (\$7) incentive payment will be available to physicians who provide the Fecal Occult Blood Test (FOBT) kit directly to the patient. Q150A may be billed once per patient per 730 day period.

*FOBT Completion Fee: Q152A*

Effective April 1, 2008, the Q152A five dollar (\$5) incentive payment will be available to all eligible primary care physicians in Ontario to be submitted once the patient's FOBT results have been reviewed by the primary care physician and communicated to the patient. Q152A may be billed once per patient per 730 day period.

**Cumulative Preventive Care Enhancement Codes**

A group may claim the following Service Enhancement Codes on behalf of the individual physician who has administered a high cumulative level of preventive care to his or her roster of patients. A group may make one claim per year for each physician under each of the following five headings per year:

*Influenza Vaccine for Enrolled Patients over 65*

This Service Enhancement Fee is payable to the physician and calculated annually on an individual physician basis, based on the percentage of patients enrolled to the physician who are over the age of 65 and who have received the influenza vaccine appropriate for that influenza season before December 31 of that fiscal year.

Percentage of Enrolled Patients	Fee Payable	Service Enhancement Code
60%	\$220	Q100A
65%	\$440	Q101A
70%	\$770	Q102A
75%	\$1,100	Q103A
80%	\$2,200	Q104A

*Pap smear*

This Service Enhancement Fee is payable to the physician and calculated annually on an individual physician basis, based on the percentage of female patients enrolled to the physician who are between 35 and 70 years of age and who have had a Pap smear in the past 30 months.

Percentage of Enrolled Patients	Fee Payable	Service Enhancement Code
60%	\$220	Q105A
65%	\$440	Q106A
70%	\$660	Q107A
75%	\$1,320	Q108A
80%	\$2,200	Q109A

*Mammogram*

This Service Enhancement Fee is payable to the physician and calculated annually on an individual physician basis, based on the percentage of female patients enrolled to the physician who are between 50 and 70 years of age and who have had a mammogram in the past 30 months.

Percentage of Enrolled Patients	Fee Payable	Service Enhancement Code
55%	\$220	Q110A
60%	\$440	Q111A
65%	\$770	Q112A
70%	\$1,320	Q113A
75%	\$2,200	Q114A

*Immunizations for Enrolled Patients under Two Years*

This Service Enhancement Fee is payable to the physician and calculated annually on an individual physician basis, based on the percentage of patients enrolled to the physician who are between 18 and 30

months of age, and who have received all ministry supplied immunizations recommended by the National Advisory Committee on Immunization. To claim this Service Enhancement Fee, the physician must retain detailed records, including the name of the vaccine, lot number, manufacturer, date of immunization, and route of administration.

Percentage of Enrolled Patients	Fee Payable	Service Enhancement Code
85%	\$440	Q115A
90%	\$1,100	Q116A
95%	\$2,200	Q117A

#### *Colorectal Screening*

This Service Enhancement Fee is payable and calculated annually to the physician based on the percentage of patients enrolled to the physician who are between 50 and 74 years of age and who have had a fecal occult blood test in the previous 30 months.

Percentage of Enrolled Patients	Fee Payable	Service Enhancement Code
15%	\$220	Q118A
20%	\$440	Q119A
40%	\$1,100	Q120A
50%	\$2,200	Q121A
60%	\$3,300	Q122A
70%	\$4,000	Q123A

## Chronic Disease Management

### **Diabetes Management Incentive**

The Diabetes Management Incentive is a \$60 annual payment available to physicians for coordinating, providing and documenting all required elements of care for enrolled diabetic patients. This requires completion of a flow sheet to be maintained in the patient's record, which includes the required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association (CDA) 2003 Clinical Practice Guidelines.

### **Congestive Heart Failure Management Incentive**

The Heart Failure Management Incentive (fee code Q050A) is a \$125 annual payment available to physicians for coordinating and documenting all required elements of care for enrolled heart failure patients. A physician is eligible to submit for the Heart Failure Management Incentive annually for an enrolled heart failure patient once all the required elements of the patient's heart failure care are documented and complete. This may be achieved after a minimum of two patient visits.

## Attachment C – Specific Service Care Incentives and Premiums

Family physicians in Family Health Teams are eligible for the service care incentives and premiums listed in this section.

### **Special Premiums**

#### **1. Premiums for Primary Health Care of Enrolled Patients with Serious Mental Illness**

Physicians shall receive an additional \$1,000 per fiscal year when providing primary care to at least five (5) enrolled patients with diagnoses of bipolar disorder or schizophrenia during that fiscal year. Fee Schedule codes for services provided to these patients must be accompanied by specific codes (which vary by physician compensation model). Physicians shall receive an additional \$1,000 (\$2,000 in total) for an additional five (5) patients [at least ten (10) patients in total] subject to the rules provided above.

#### **2. Obstetrical Coverage**

Effective October 1, 2007, physicians shall receive an additional \$5,000 after submitting valid claims for providing a minimum of 5 deliveries services from the list set out below to five (5) or more patients (enrolled or non-enrolled) in any fiscal year.

**The following codes are used to determine whether a physician has met the threshold for the special payment for obstetrical services:**

- P006A Vaginal delivery;
- P009A Attendance at labour and delivery;  
    [Note: Anaesthesia or assistant units are not eligible when the same physician claims P009A on the same patient.]
- P018A Caesarean section – procedure only;
- P020A Operative Delivery (i.e. mid-cavity extraction or assisted breech delivery other than Caesarean section);
- P038A Attendance at labour when patient transferred to another centre for delivery; and
- P041A Caesarean section with tubal interruption.

#### **3. Hospital Services**

A physician shall receive an additional \$5,000 after submitting valid claims for services totalling \$2,000 in any fiscal year from the list of services rendered to enrolled and non-enrolled patients, as set out below. For areas with an OMA Rurality Index of Ontario (RIO) score greater than 45, and in Timmins, Thunder Bay, North Bay, Sault St. Marie and Sudbury, the hospital premium is \$7,500.

**The following codes are used to determine the threshold for payment of the special payment for hospital services:**

- A933A On-call general assessment;
- C002A Subsequent visits to five (5) weeks;
- C003A General assessment;
- C004A General re-assessment;
- C005A Consultation;

- C006A Repeat consultation;
- C007A Subsequent visits 6th-to-13th week [Maximum three (3) per patient per week];
- C008A Concurrent care;
- C009A Subsequent visits after 13th week [Maximum six (6) per patient per month];
- C010A Supportive care;
- C121A Additional visits due to intercurrent illness (see General Preamble for terms and conditions);
- C777A Pronouncement of death;
- C905A Limited consultation in hospital;
- C933A On-call admission general assessment; and
- H001A Newborn Care in hospital and/or home.

#### **4. Palliative Care**

A physician shall receive an additional \$2,000 after submitting valid claims for fee schedule code K023A for four (4) or more palliative care patients (enrolled or non-enrolled) in any fiscal year.

#### **5. Prenatal Care**

A physician shall receive an additional \$2,000 after submitting valid claims for fee schedule codes P003A and/or P004A for prenatal care during the first 28 weeks of gestation for five (5) or more enrolled patients in any fiscal year.

#### **6. Home Visits (Other than Palliative Care)**

A physician shall receive an additional \$2,000 after submitting valid claims for fee schedule codes A901A and/or A902A for one hundred (100) or more home visits to enrolled patients in any fiscal year.

#### **7. Special Payment for Office Procedures**

A physician shall receive an additional \$2,000 after submitting valid claims for services to enrolled patients totalling \$1,200 or more in any fiscal year.

Through shadow billing, nurse practitioners may contribute to attaining bonuses for Prenatal Care, Home Visits, or Special Payment for Office Procedures.

The physician will receive payment for the higher premium between the Obstetrical Deliveries and Prenatal Care special premiums, not for both.

## **Incentive**

### **1. Newborn Care Episodic Fee**

Physicians are eligible for an additional payment for up to eight (8) well baby visits (A007A) for enrolled patients in the first year of life. The add-on code (Q014A for FHNs and Q015A for FHOs) must accompany each submitted claim in order for the premium to be paid.

## **Enrolment**

### **1. New Patient Fee (Q013A)**

Physicians practicing in all models are eligible to claim a fee for accepting new patients into their practice each fiscal year (April 1 to March 31). This is a one-time fee and requires the completion of a New Patient Declaration form by the physician and patient.

The fee may be claimed for up to sixty (60) patients annually and is \$100 for patients under 65 years of age, \$120 for patients between 65 and 74 years of age, and \$180 for patients aged 75 years or older. Conditions and limitations on claiming the new patient fee are specified in the *Memorandum of Agreement* between the ministry and the OMA.

## **2. New Graduate-New Patient Fee (Q033A)**

Newly graduated physicians are eligible, during their first year of comprehensive primary care practice (commenced within three years following graduation), for a new patient fee of \$100 for patients under 65 years of age, \$120 for patients between 65 and 74 years of age, and \$180 for patients aged 75 years or older, to be paid for up to three hundred (300) persons who qualify as new patients.

## **3. Unattached Patient Fee (Q023A)**

An incentive in the amount of \$150 will be paid to physicians on a per patient basis for the enrolment of a patient previously without a family physician, following the patient's discharge from an acute care in-patient hospital stay. This fee is not payable in addition to the New Patient Fees Q013A and Q033A.

## **4. Complex/Vulnerable New Patient Fee**

A one-time payment of \$350 will be paid to physicians for attaching a patient from the Health Care Connect program. For more information on this code, please consult with your ministry contact.

## **5. Enhanced Payments**

Physicians are eligible to receive an enhanced payment of \$500 for caring for each complex/vulnerable patient for 12 consecutive months from the patient's enrolment effective date.

## **6. Mother/Newborn New Patient Fee**

Physicians who enrol as a new patient an unattached mother within two weeks of giving birth are eligible for a \$350 fee for enrolling both the mother and the newborn. Physicians who enrol an unattached woman after 30 weeks of pregnancy will be eligible for the \$350 new patient fee providing the newborn is enrolled at birth and receives appropriate care within two weeks of birth and both are enrolled within three months. In case of multiple births, physicians are eligible for the new Unattached Multiple Newborn fee (paid at \$150) for each additional newborn of an unattached mother. For more information on these codes, please consult with your ministry contact.

## **7. New Patient Fee FOBT Positive/Colorectal Cancer Increased Risk (Q043A)**

Physicians who enrol unattached patients with a positive FOBT or with an increased risk of colorectal cancer are eligible for this fee, which pays:

- \$150 for patients up to and including 64 years of age;
- \$170 for patients 65 to 74 years of age; and
- \$230 for patients 75 years of age or older.

## **Rurality**

All compensation models include an incentive based upon the degree to which the community being served is determined to be rural. These payments are intended to provide additional incentives for physicians to work in rural and remote communities and are based upon the Rurality Index of Ontario (RIO) score methodology developed by the OMA. To be eligible for this incentive, a physician must practice in a community with an OMA RIO score greater than or equal to 45 to qualify for an annual premium of \$5,000. Each additional increment of "5" in the RIO score triggers an increase in payment by \$1,000.

## After Hours Care Requirements and Payments

### **After Hours Obligations**

Family Health Teams will provide regular after hours and weekend care to their patients. The specific number of hours and requirements will form part of the Family Health Team agreement with the ministry. In some communities, depending on need, these hours may vary or may be waived if more than 50% of the physicians provide regular anaesthesia, emergency department or obstetrical services.

Physicians working after hours will be entitled to claim an additional incentive payment currently valued at 20% of the value for specific fee-for-service claims that are billed for a number of commonly claimed services.

All Family Health Team patients will have access to the integrated Telephone Health Advisory Service (THAS) funded by the ministry. One physician is to respond in the event that the THAS nurse needs to seek the physician's advice. Refer to the *Guide to Telephone Health Advisory Service (THAS)* for more information on this service.

### **After Hours Premium (Q012A)**

The ministry shall pay the Family Health Team a 20% premium on the full value of fee codes A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A for valid claims for After Hours Services (including statutory holidays) provided to enrolled patients.

## Continuing Medical Education Incentive

### **Targeted Medical Education Service Enhancement Codes**

A Service Enhancement Fee of \$100 per hour is payable annually to a physician for each hour that he or she spends at a MAINPRO-M1 and/or MAINPRO-C continuing medical education conference or seminar, subject to the following conditions:

- a) The conference/seminar must have been approved by a joint committee of the OMA, the ministry, Institute of Clinical Evaluative Sciences, and the Ontario College of Family Physicians;
- b) The physician may claim a maximum of 24 hours per year; and
- c) The physician must retain proof of attendance at the conference/seminar.

## Attachment D – Blended Capitation Models for Physicians

The blended capitation physician compensation model is a blend of capitation payments, fee-for-service, premiums, and bonus incentives. There are two blended capitation models available to physicians: the Family Health Network (FHN) and the Family Health Organization (FHO). The following is a brief description of the major components of this model.

### **Eligibility**

The blended capitation is available to groups consisting of at least three (3) signatory physicians.

### **Capitation Payments**

There are two capitation payments paid for enrolled patients in a blended capitation model:

- The Base Rate Payment (BRP), which is based on the patient’s age and sex or on their Long-Term Care status; and
- The Comprehensive Care Capitation Payment.

The BRP is an amount paid monthly per enrolled patient for a basket of core services (codes vary by model type, see section “FHN/FHO Comparison”). The BRP is reduced by 50% after the group threshold is met. The group threshold roster is calculated as 2,400 multiplied by the number of signatory physicians.

The Comprehensive Care Capitation Payment is an average monthly capitation rate per enrolled patient.

The Long-Term Care BRP is the net base rate payment for all long-term care patients, and is based on 82 core Long-Term Care codes.

### **Shadow Billing Premiums**

Shadow billing premiums are paid at 10% of the value of fee-for-service payments for core services to enrolled patients as stipulated by the agreement (FHN or FHO) and by the patient’s status (Long-Term Care or non-Long-Term Care).

Core services to non-enrolled patients are paid 100% of the fee-for-service value. These claims have a Hard Cap applied after the first year in a blended capitation model. Each physician has a Hard Cap of \$48,500, which is pooled at the group level. Billings beyond that maximum are reconciled.

Excluded codes (such as hospital, reproductive and emergency room) are paid at 100% of the fee-for-service value for enrolled and non-enrolled patients. Excluded codes do not have a Hard Cap.

### **Access Bonus**

The Access Bonus is a payment to blended capitation groups for exclusively providing core services to their enrolled patients. The Access Bonus is calculated at the group level and is the sum of each physician’s Access Bonus, whether negative, positive or zero. Where the amount for the group is either zero or negative, there is no Access Bonus payment or reconciliation for the period.

The Access Bonus is calculated as follows:

- Access Bonus (AB) = Maximum Special Payment (MSP) – Outside Use (OU)
  - Where:

- MSP = the sum of all eligible enrolled patients’ Base Rate Payment (monthly for FHOs and semi-annual for FHNs) multiplied by an access bonus multiplier (varies by model, see “FHN/FHO Comparison”).
- OU = the value of fee-for-service claims for core services provided to patients enrolled to the FHN/FHO by general practitioners outside the group.

Oculovisual assessments (A110A, A112A), core services provided by identified GP Psychotherapists, and in certain circumstances core services provided by non-blended capitation model physicians in conjunction with a Special Visit to a Hospital Emergency Room Department, do not contribute to Outside Use.

**Special Premiums**

Blended capitation physicians are eligible for all the premiums and incentives outlined in Attachments B and C.

**Group Management Leadership Payment**

Each blended capitation group will receive one dollar (\$1) per fiscal year for each enrolled patient, up to an annual maximum of \$25,000.

**FHN/FHO Comparison**

<b>Components</b>	<b>Family Health Networks</b>	<b>Family Health Organizations</b>
Average Base Rate Payment <sup>7</sup>	\$117.03	\$128.25
Number of Core Codes	56	119
Newborn Episodic Fee & Code	Q014A - \$15.05	Q015A - \$13.99
Serious Mental Illness Code	For schizophrenia bill code 295	For schizophrenia bill code Q021A
Access Bonus Payment	Semi-annually	Monthly
Access Bonus Multiplier for Enrolled Patients (LTC & non-LTC)	0.2065 – non-LTC and LTC patients	0.1859 – non-LTC patients 0.2065 - LTC patients

For additional information on Blended Capitation Models, please consult with your ministry contact.

<sup>7</sup> Provincial Average Net Capitation including Seniors Care Premium.

## Attachment E – Blended Complement Model

The Blended Complement Model provides compensation based on the number of physicians with the group. The model provides a base remuneration for the provision of comprehensive care, plus incentives, premiums and special payments for the provision of specific primary health care services, and funding for emergency services coverage.

### **Eligibility**

The Rural and Northern Physician Group Agreement (RNPGA) is the blended complement compensation model that is available to physicians in Family Health Teams in communities designated as underserved and with a complement of 1–7 physicians.

### **Service Expectations**

#### *Primary Care*

This model provides funding on the basis of a commitment by the group to provide, coordinate or oversee the core primary health care services. The group is responsible to ensure that a sufficient number of physicians are available to provide these services during reasonable and regular service hours, totalling at least forty (40) hours from Monday through Friday. Evening and weekend hours shall also be provided by the group at an appropriate location of their choice.

#### *24/7 Coverage*

In communities with a hospital-based emergency program, the group is expected to provide 24/7 emergency department coverage. If the community does not have a hospital, the physicians are expected to cover 24/7 on-call coverage, subject to reasonable availability.

#### *Hospital, Home and, where applicable, Long-Term Care Homes Services*

Where applicable and where possible, the group will provide inpatient services to any hospital or long-term care home present in the community, and assist with discharge planning, rehabilitation services, outpatient follow-up and home-care services.

### **Funding and Benefits**

#### *Base Funding*

This model provides funding based on the complement of physicians working on the agreement, up to the designated number of physicians for the community. An annual amount is provided that includes funding for services, as well as any associated overhead costs in managing the services within the community.

### **Emergency Department Coverage**

For eligible communities (those with a hospital Emergency Program) funding is available for 24/7 coverage of the emergency department, shared among the group physicians. Annual funding amounts are determined based on the complement size of the group, and a global amount is funded to the group for the provision of these services. Any second on-call work that is required is eligible for fee-for-service billing.

For communities without a hospital Emergency Program, funding is provided for 24/7 on-call availability. This availability is subject to reasonable expectations of physician capabilities.

### **Rurality Incentive Payment**

Additional funding is available to the group based on a pre-determined rurality scoring. This funding is in addition to the base funding and is in recognition of the impact that rurality may have on work load and physician recruitment and retention.

### **Shadow Billing**

This model funds a payment incentive of 5% of all valid codes that are billed using the current OHIP billing system for services provided by the group physicians.

### **Fee-For-Service Billing**

This model allows fee-for-service billing on all obstetrical work. Furthermore, any of the “specialized services” described above, may be billed fee-for-service if done after hours (nights and weekends).

### **Specialized Services**

This model provides additional funding for specialized services provided by members of the group to the community. The specialized services, for which additional funding may be available, are:

- Obstetrical delivery services;
- Minor surgical services (evening and weekend only);
- Assistance in surgery (evening and weekend only); and
- Anaesthesia services (evening and weekend only).

### **Group Management and Leadership Payment**

Physicians working in this model are eligible for a group management and leadership payment, based on the number of enrolled patients enrolled with the group.

### **Premiums and Incentives**

Physicians in this model are eligible for all of the incentives and premiums described above, including Continuing Medical Education, Preventive Care and After Hours Service Payments.

### **Rural Family Medicine Locum Program**

Group physicians in this model are eligible for 37 days of locum coverage annually. The locums are to be arranged with the assistance of the Rural Family Medicine Locum Program, subject to the availability of locums. Furthermore, any vacant positions within the group (based on the physician designation) are still eligible for 37 days of locum coverage, accumulated at three per vacancy per month, to be used by the group.

### **Maternity/Parental Leave**

Physicians in this group are eligible for a maternity/parental leave benefit as outlined in the agreements. Group 2 physicians are paid at 50% of the portion of the complement based payment identified as physician compensation, and the full amount of the administrative portion of the payment is paid.

For additional information on the Blended Complement Model, please consult with your ministry contact.

## Attachment F – Family Health Team Blended Salary Model for Physicians

### **Eligibility**

The Blended Salary Model will be made available to primary care physicians employed by a community-sponsored or mixed-governance<sup>8</sup> Family Health Team.

### **Funding and Benefits**

#### *Base Funding*

Salary levels are linked to an individual physician's target roster size. The salary levels available as of April 1, 2008, are as follows:

Salary Level	Target Roster Size	Salary
Level 1	1,300	\$137,204.11
Level 2	1,475	\$155,564.74
Level 3	1,650	\$173,925.38

Salary level determination will be based on a physician's actual roster in comparison to target roster size as of March 31st of the previous fiscal year. Blended Salary Model physicians are expected at the outset to attain one of the three target roster sizes (1,300, 1,475 or 1,650) and then to sustain enrolment with as little variance as manageable around that target. A physician's salary will be at Level 1 upon enrolling 1,300 patients, and will increase from Level 1 to Level 2 upon enrolling 1,475 patients and from Level 2 to Level 3 upon enrolling 1,650 patients. The maximum salary paid for Level 3 is \$173,925.38.

#### *Benefits*

Benefits are calculated at 20% of the physician salary. This component is paid directly to the Family Health Team, which has the responsibility in conjunction with the physician on whose behalf the payment is made to determine the benefit compensation package.

Benefit payments to the Family Health Team will be pro-rated for part-time physicians.

### **Part-Time Blended Salary Physicians**

Physicians with a roster fewer than 1,300 patients are considered to be part-time and, as such, their base salary will be pro-rated accordingly on a per-patient basis proportional to blended salary Level 1. In addition, part-time physicians are entitled to payments as per Schedule "E" of the Community-Sponsored Family Health Team Contract.

Furthermore, part-time physicians are eligible to earn pro-rated payments or receive pro-rated funding for other Blended Salary Model components, including an Access Bonus, benefits, locum coverage and information technology support.

The Community Sponsor (CS) is accountable to ensure that the responsibilities and service obligations owed by physicians, in exchange for the base salary, will be provided to the Family Health Team. The CS will be expected to negotiate a physician service commitment commensurate to the salary. It is suggested

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<sup>8</sup> For information on eligible governance models, please refer to the *Guide to Governance and Accountability*.

that the physician service commitment be relative to the physician’s roster size and proportional to the full-time equivalency at blended salary Level 1<sup>9</sup>.

The following chart outlines the relationship between a physician’s roster size, base salary, FTE and the relative service commitment, and may provide guidance to the CS when negotiating a part-time physician’s service commitment to the Family Health Team.

<b>Roster Size</b>	<b>Estimated Base Salary (\$105.54 per patient)</b>	<b>FTE Proportional to Roster Size</b>	<b>Suggested Hours of Service per Week to the FHT</b>
1,300	\$137,204.11 <sup>10</sup>	1.0	40
1,170	\$123,483.70	0.90	36
1,040	\$109,763.29	0.80	32
910	\$96,042.88	0.70	28
780	\$82,322.47	0.60	24
650	\$68,602.06	0.50	20
520	\$54,881.64	0.40	16
390	\$41,161.23	0.30	12
260	\$27,440.82	0.20	8

### **Operational Overhead**

The ministry will provide funding for each Family Health Team to recognize related operational overhead expenses for each Blended Salary Model physician.

### **Locum Coverage**

Family Health Teams that do not qualify under the Rural Family Medicine Locum Program at HFO MRA are eligible for locum funding equal to 5% of each BSM physician’s salary.

### **Shadow Billing Premium and Fee-For-Service Billings**

This model funds a payment incentive of 5% of all valid claims in accordance with the *Health Insurance Act* for core services provided to enrolled patients.

<sup>9</sup> The minimum roster size at blended salary Level 1 is equal to 1,300 patients.

<sup>10</sup> Salary as of April 1, 2008. This salary is subject to change, based on fee-for-service increases.

## Income Stabilization for Blended Salary Model Physicians

### **Purpose**

Income stabilization supports eligible full-time and part-time physicians, as they develop patient rosters in a Family Health Team. Income Stabilization Funding is available for a period of up to 12 months, at which time the physician is required to transition to the Blended Salary Model.

### **Eligibility**

Income stabilization is available to physicians who wish to join the Blended Salary Model in exchange for service and a commitment to enrol patients within the Family Health Team.

The following physicians are eligible for income stabilization funding:

1. New graduates<sup>11</sup>;
2. Physicians without an Ontario fee-for-service billing history; or those participating in a non fee-for-service compensation model; and
3. Physicians with a minimum of 12 months of Ontario fee-for-service billing history.

Please note, at the present time, physicians who are signatory to a primary care model with a current roster of enrolled patients are not eligible for income stabilization. However, if the physician relocates his/her roster to the Family Health Team, these physicians would be eligible to commence the Blended Salary Model and receive all the benefits of the model, or may choose to continue to develop their roster as outlined in the *Family Health Team Blended Salary Model for Physicians* fact sheet.

### **Payment and Enrolment**

New graduates and physicians without an Ontario fee-for-service billing history are eligible for a guaranteed first year annual baseline income of \$174,177.19 inclusive of benefits.

Those with an Ontario fee-for-service billing history or who are participating in an alternate general practice payment model will be eligible for an income stabilization annual income between \$137,204.11 to a maximum of \$173,925.38 excluding benefits. Determination of income stabilization payment is calculated at 65% of the previous 12 consecutive months of the physician's solo and group billings.

For physicians within an alternate payment model, an amount will be determined based on the range above. This payment excludes overhead as Family Health Teams will submit requests for physician overhead through their business and operational plans.

Physicians participating in the Income Stabilization Program will also have the ability to bill the Ontario Health Insurance Plan (OHIP) for some services. Conditional on the physician(s) fulfilling their required hours of service to the team, there will be no limit on fee-for-service billings for services provided at premises outside the Family Health Team to non-enrolled patients.

Outside services refers to services provided to non-enrolled patients in locations other than Family Health Team premises or utilizing any of the support staff or services of the Family Health Team.

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<sup>11</sup> The phrase "new graduate" pertains to a physician who graduated no more than three years prior to the date that he/she signed the *Community Sponsored Family Health Team Template Agreement* or any patient-enrolment model. For example, if a physician joins a Family Health Group in Year 1, and then joins the BSM model, the new graduate period is over.

Physicians may bill OHIP for services specific to emergency room unscheduled visits and obstetrical deliveries, and receive 100% of the fee-for-service value for their enrolled and non-enrolled patients. Applicable codes include:

K990, K991, K992, K993, K994, K995, K996, K997, H055, H065, H101, H102, H103, H104, H105, H112, H113, H121, H122, H123, H124, H131, H132, H133, H134, H151, H152, H153, H154, H400, H401, H402, H403, H404, H405, H406, H407, H408 and P006, P020, E502, P018, P041, P042, E500, P038, P009, P010, C989, E411, E414, P028, Z774, P036, P039, P029, P013, P014, P015, P016, E100, G224<sup>12</sup>, Z776, Z734, P030, P022, P023, Z775, P031, P034, Z777, E409 and E410 for billable suffixes A, B and C.

(Note: Fee codes billed in association with the above 'K' codes are also included.)

Physicians are ineligible to submit claims to OHIP for services provided to patients within the Family Health Team.

For auditing purposes, physicians receiving income stabilization payments are advised to shadow-bill services provided within their Family Health Team.

During the income stabilization period, physicians will retain all *Patient Enrolment and Consent to Release Personal Health Information* forms. The physician must notify the ministry sixty (60) days prior to their intent to commence the Blended Salary Model, and will be required to submit all *Patient Enrolment and Consent* forms for processing at this time.

Once a physician has officially commenced the Blended Salary Model, he/she will be eligible to receive all the benefits under the Blended Salary Model, including the Per Patient Rostering Fee (Q200), the New Patient Fee (Q013), the New Graduate-New Patient Fee (Q033), the Unattached Patient Fee (Q023), and the New Patient Fee FOBT Positive/Colorectal Cancer Increased Risk (Q043A).

Income stabilization payments are flowed directly to the Family Health Team that compensates the physician. Physicians are expected to use reasonable efforts to enrol the target roster size that reflects their FTE status during the income stabilization period.

For full-time physicians (1.0 FTE), the minimum target roster is 1,300 patients, and this baseline will be used to calculate the proportional target roster for part-time physicians. Upon request from the ministry, Family Health Teams will supply information concerning enrolment activity of participating physicians during the 12 month income stabilization period.

The table on the next page summarizes the Full-Time Income Stabilization options for Blended Salary Model physicians, outlining payment in relation to benefits and overhead.

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<sup>12</sup> G224 needs to be billed in conjunction with one of the following obstetrical fee codes in order to be eligible for fee-for-service billing: P006, E414, P009, P020, P022, P023, P028 and P030.

<b>Physician Status</b>	<b>Income Stabilization Payment (One year)</b>	<b>Benefits</b>	<b>Overhead</b>
New graduates and physicians without an Ontario fee-for-service billing history	\$174,177.19	Included within payment	Excluded from payment
Physicians with a 12-month Ontario fee-for-service billing history or participating in a non-fee-for-service compensation model	\$137,294.11 - \$173,925.38 <sup>13</sup>	Excluded from payment	Excluded from payment

### **Part-Time Income Stabilization**

Physicians may also choose to be compensated on a part-time basis in the Blended Salary Model Income Stabilization Program, at a minimum service commitment of one day per week to the Family Health Team. The physician's income stabilization payment will be pro-rated based upon their FTE status, and will be proportional to their full-time income stabilization entitlement, using 40 hours as the determinant for full-time. Enrolment targets for part-time physicians will also be proportional to the full-time equivalency requirements.

In addition to the standard terms and conditions noted above, the following will apply to the part-time Blended Salary Model Income Stabilization Program:

- Physicians must actively enrol patients during the income stabilization period;
- Part-time physicians must communicate to their enrolled patients the days that they are available and that patients may access care from other members of the Family Health Team when necessary;
- The Family Health Team is responsible to ensure that the part-time physician participates in providing the required after hours service coverage and that another member physician is available to care for the part-time physician's patients when he/she is not available; and
- The Family Health Team will be responsible for ensuring all the requirements of the part-time Income Stabilization Program are met, including the physician's required service commitment to the Family Health Team.

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<sup>13</sup> Salary as of April 1, 2008. The salary is subject to change, based on fee-for-services increases.

The following table has been adapted from the *Part-Time Blended Salary Model* fact sheet to illustrate the Part-Time Income Stabilization option in relation to suggested hours of service and target roster size.

<b>FTE</b>	<b>Suggested Hours of Service per Week to the FHT</b>	<b>Target Roster Size</b>
1.0	40	1,300
0.90	36	1,170
0.80	32	1,040
0.70	28	910
0.60	24	780
0.50	20	650
0.40	16	520
0.30	12	390
0.20	8	260

For additional information on the Blended Salary Model please consult with your ministry contact.