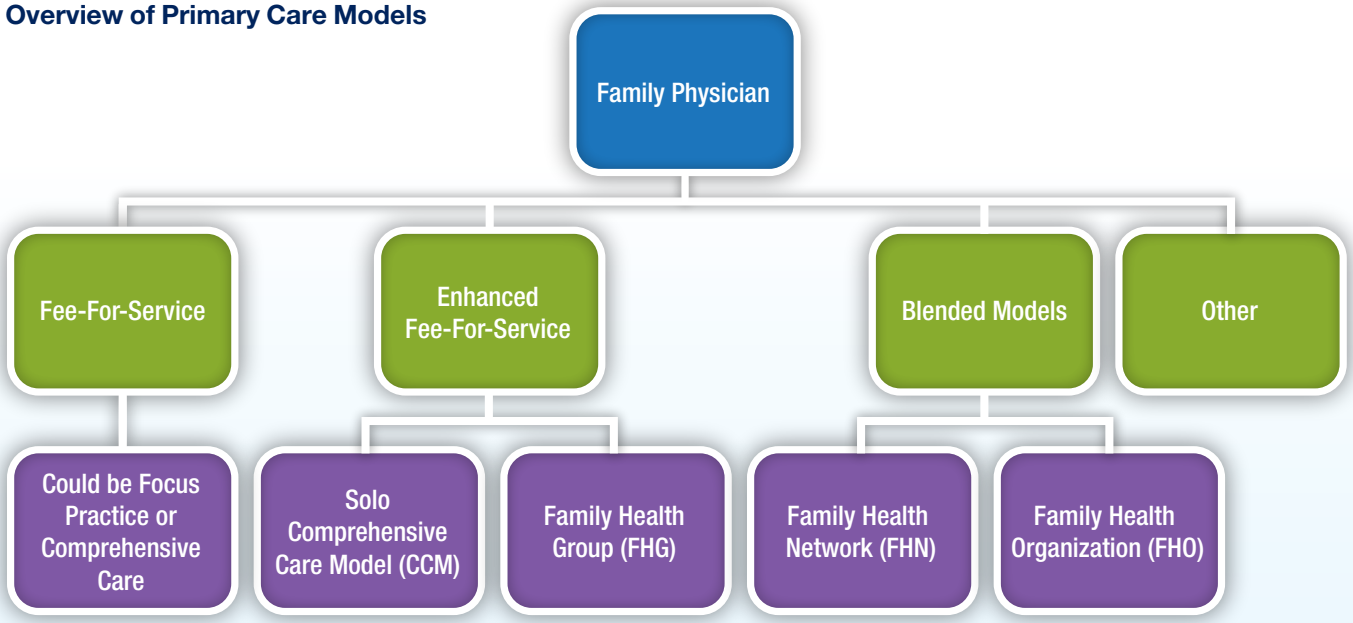
OMA MEMBER RESOURCE

Primary Care Model Overview

by OMA Economics, Research and Analytics Department

The following material, prepared a resource for OMA members, is intended to provide an overview and comparison of the various primary care models established in the province of Ontario, including the recent New Graduate Entry Program. For additional details or questions, please refer to the contact information on page 6.

Overview of Primary Care Models



Fee For Service

Physicians bill OHIP in accordance to the Schedule of Benefits.

Comprehensive Care Model

The Comprehensive Care Model (CCM) is an initiative designed to encourage physicians to provide comprehensive primary health care to their patients and to reward them for doing so. Compensation is based on individual fee-for-service billing with incentives and enhanced fees. There is a service requirement that the physician provide after-hours coverage. Designed for individual physicians.

Family Health Group

A Family Health Group (FHG) is a collaborative comprehensive primary care delivery model involving three or more physicians practicing together. The physicians participating in the group need not be located in the same physical office space, but must be within reasonable distance of each other in order to facilitate care. Physicians practicing in a FHG model will be rewarded for delivering comprehensive primary care through payment incentives for a wide range of services, including after hours. Compensation is primarily based on individual fee-for-service billings, with incentives and enhanced fees. A minimum of three physicians are required to create a Family Health Group.

Family Health Network

A Family Health Network (FHN) is a collaborative comprehensive primary care delivery model involving three or more physicians practicing together. Core services of the FHN group are funded primarily through capitation (fee per patient) that is adjusted by the age and sex of the patient. A minimum of three physicians are required to create a Family Health Network.

Family Health Organization

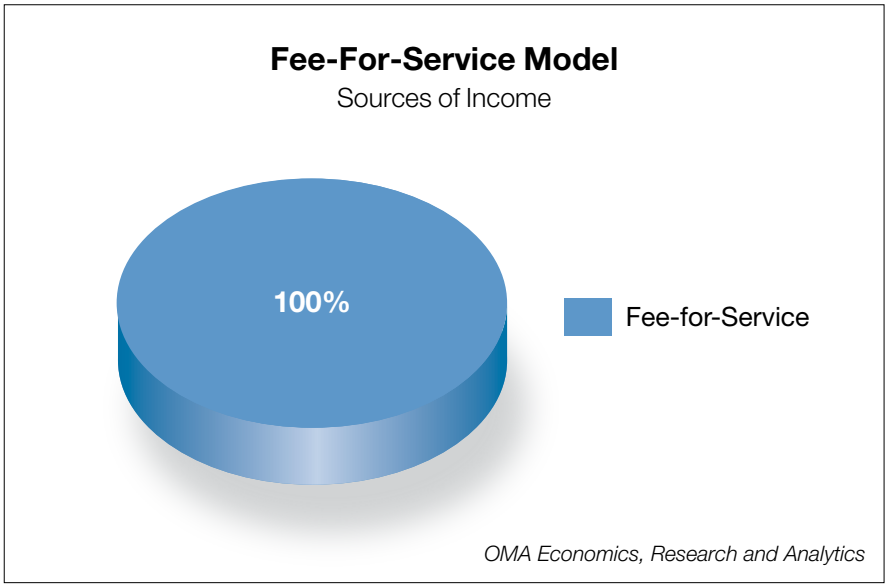
A Family Health Organization (FHO) is a collaborative comprehensive primary care delivery model involving three or more physicians practicing together. Similar to the FHN, the core services of the FHO group are funded primarily through capitation (fee per patient) that is adjusted by the age and sex of the patient. A minimum of three physicians are required to create a Family Health Organization.

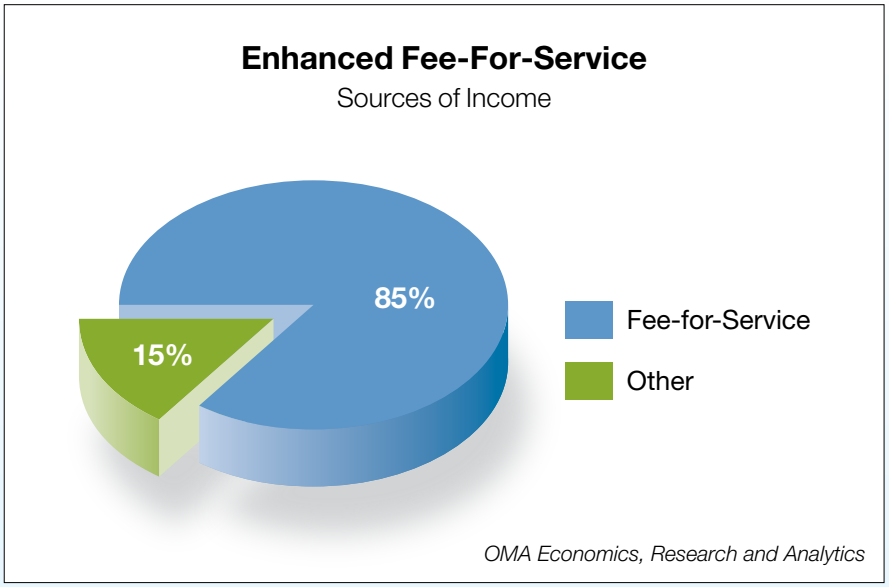
New Grad Entry Program (NGEP) Income Impact Analysis:

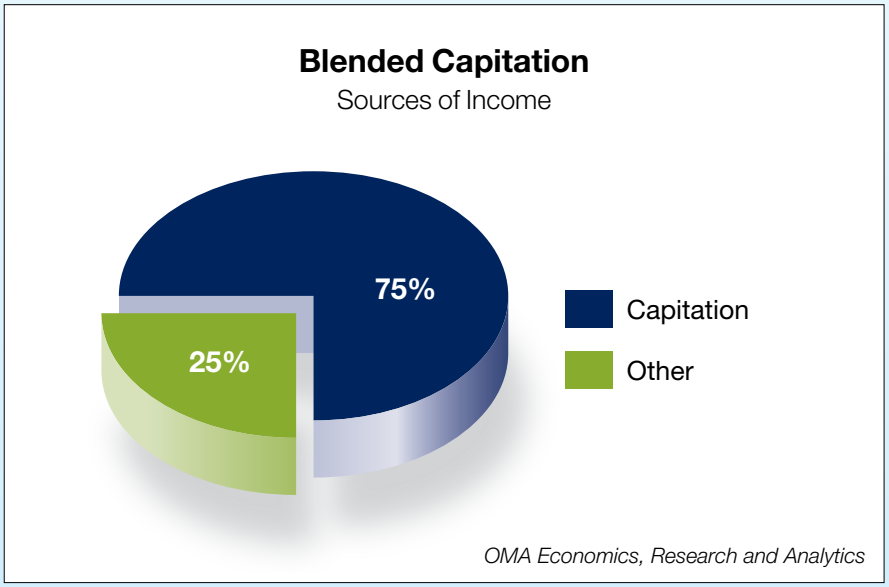
New Grad Entry Program

The NGEP provides participants a guaranteed income if roster targets are met for the first three years of practice. The average annual income is $182,000 per year ($162K, $178K, $207K in years 1 to 3, respectively). Changes to the NGEP announced May 2, 2016 (INFOBulletin #11147) allow for $35K in permissible Fee For Service (FFS) billings in each year. These FFS billings are restricted to a mix of "designated services" and "non-designated services". Since these billings are optional and restrictive we have not included them in the analysis below. When compared to the actual annual earnings of new family practice graduates in the first three years of practice, the NGEP represents a reduction in earnings by an average of about $30K per year. This reduction varies significantly depending on the model of practice:

- The majority of new entrants (i.e., about 55%) are not in the same model for the entire first three years of practice, most begin in Enhanced FFS (i.e., CCM or FHG) and move to capitation during this period. For this group, the NGEP results in an income reduction of about $70K per year. That is, a predicted actual average annual income of approximately $250K versus the $182K NGEP income.
- For the relatively few entrants that enter and stay in capitation for the entire three-year period (i.e., about 10% of new entrants) the reduction in income is much larger, about $120K. That is, a predicted actual average annual income of approximately $300K versus the $182K NGEP income.
- For the 35% of new entrants who practice pure FFS for the first three years, the NGEP provides an increase in earnings of about $50K per year. That is, a predicted actual average annual income of approximately $130K versus the $182K NGEP income. ■







Primary Care Comparison Chart

Fee-for-Service, Comprehensive Care Model, Family Health Group, Family Health Network, and Family Health Organization.
Updated as of June 2015

Please note that the 3.15% fee reduction imposed by the Ministry of Health (0.5% effective April 1, 2013 and 2.65% effective June 1, 2015) is not included in any of the values below.

Elements	Fee-for-Service (FFS)	Comprehensive Care Model (CCM)	Family Health Group (FHG)	Family Health Network (FHN)	Family Health Organization (FHO)
Group Size	No minimum	One (1) Physician	Minimum Three (3) Physicians		
Payments	Directly to physician			There is option to have all payments except for the Access Bonus, GMLP and Administrative Support Funding, made directly to each physician.	
Enrolment/ Registration		Required to receive applicable premiums.	Optional; Ministry-generated patient roster with opportunity to augment with formal enrolment.	Required. Active enrolment with formal enrolment form. Entry into FHN/FHO allowed only in areas of high need, and limited to 20 physicians per month, unless replacing physician.	
Availability	Unrestricted			For physicians commencing in FHN or FHO effective June 1, 2015 and onwards, monthly registration into these models will be limited to 20 physicians per month in areas of high need, non-patient-enrolment model physicians only. Physicians may join a FHN or FHO to replace an existing group physicians in any area of the province, regardless of high need status.	
FFS Billing	Per OHIP Schedule of Benefits (SOB) for all services provided.		FFS billings at current SOB rate. Plus Comprehensive Care Incentive (see below).	There is no FFS limit for a group in the group's first year. After the group's first year, the FFS limit for the group's services is currently $55,950 (x # of doctors in the group) for non-rostered patients and "in-basket" services. There is no limit for FFS billings for the provision of non-group services ("out of basket," non-rostered patients). For physicians in their first year of group practice, their billings do not count towards the FFS limit of $55,950 (x # of doctors in the group).	
Basket of Services			Comprehensive Care Incentive applies to all Ministry-rostered and formally enrolled patients. 10% premium on A001, A002, A003, A007, A008, A888, A901, A902, C010, C882, G840, G841, G842, G843, G844, G845, G846, G847, G368, G538, G539, G590, G591, K005, K017, K022, K023, K030, K130, K131, K132.	**Base rate plus 15%** applicable to 64 codes for enrolled patients.	**Base rate plus 15%** applicable to 130 codes for enrolled patients.

Elements	Fee for Service (FFS)	Comprehensive Care Model (CCM)	Family Health Group (FHG)	Family Health Network (FHN)	Family Health Organization (FHO)
Comp Care Management (CCM) Fee		Upon signing a contract, Patient Enrolment Model (PEM) Physicians receive an initial average monthly capitation payment of $1.72 per enrolled patient. After 12 months, the payment is increased to $2.48. Those who do not choose to immediately provide block coverage are eligible to receive an average capitated payment of $1.15 per enrolled patient for up to six months. Effective April 1 2013, the CCM fee will be reduced by 50% for each patient a physician enrols above 2,400.			
Annual Cap/Base Rates				Age and Sex Adjusted, Average Base Rate is currently set at $126.48.	Age and Sex Adjusted, Average Base Rate is currently set at $139.12.
Access Bonus				Calculated at 20.65% of the base rate, paid semi-annually.	Calculated at 18.59% of the base rate, paid monthly.
Negation				The Access Bonus is reduced if an enrolled patient receives in-basket services from a GP outside of the group. A group's Access Bonus cannot go below zero dollars.	
Term of Contract		Indefinite.		Three (3) years from Commencement Date (renewable)	
Roster Size		No roster limit. Effective April 1, 2013, the CCM fee will be reduced by 50% for each patient a physician enrols above 2,400.		No roster limit. Base capitation rate is reduced by 50% for each patient enrolled beyond an average of 2,400 patients per physician in the group. Effective April 1, 2013, the CCM fee will be reduced by 50% for each patient a physician enrols above 2,400.	
Withdrawal/ Termination by Physicians		90 days written notice to the Ministry to terminate. As the CCM is a solo physician agreement, termination is the same as withdrawal.	90 days written notice to the Ministry to terminate. No notice requirement for an individual physician to withdraw (should be considered for group governance).	60 days written notice to the Ministry to terminate. 60 days notice is required to be provided to the Lead Physician, Ministry, and OMA for an individual physician who withdraws from a FHN/FHO.	
Income Stabilization				**Guaranteed Income** for new grads entering a FHN/FHO — $201,330.48 for urban full-time physician, $220,814.08 for rural/northern physician. For physicians commencing in the FHN and FHO models effective June 1, 2015 and onwards, participating in the Income Stabilization program will be limited to eligible physicians joining a FHN or FHO in areas of high physician need. Physicians registered on Income Stabilization prior to June 1, 2015 continue under this program until the end of their one-year term, subject to the requirements of the program.	

Primary Care Comparison Chart – Incentives

<table>
<tr><th>Incentives / Premiums</th><th>Fee for Service (FFS)</th><th>Comprehensive Care Model (CCM)</th><th>Family Health Group (FHG)</th><th>Family Health Network (FHN)</th><th>Family Health Organization (FHO)</th></tr>
<tr><td>After Hours Care</td><td></td><td>Same as FHG, FHN, FHO, but submitted with Q016A.</td><td colspan="3">Q012: Additional 30% for services to virtually rostered and formally enrolled patients. Applies to the basic office visit codes (A001, A003, A004, A007, A008, A888, K005, K013, K017, K030, K130, K131, K132, K033, Q050).</td></tr>
<tr><td>Primary Health Care of Patients with Serious Mental Illness</td><td></td><td></td><td colspan="3">$1,000 per year for five to nine (5-9) registered patients with bipolar disorder or schizophrenia.
$2,000 per year for 10 registered patients and over.</td></tr>
<tr><td>Colorectal Screening Bonus (Q150)</td><td></td><td colspan="4">Available for preventive screening using Fecal Occult Blood Testing on eligible enrolled patients between the ages of 50 – 74.</td></tr>
<tr><td>Geriatric Premium</td><td colspan="3">15% automatic premium for A003, A903, C003, C903, W102, W109, W903, A004, C004, W004, A007, A901, A917, A927, A937, A947, A957 A967 and K132 for patients over 65 years of age.</td><td colspan="2">Physicians receive an additional 15% payment for Base Rate and CC Capitation Payments for enrolled patients 65 years of age and older. Rates are automatically adjusted.</td></tr>
<tr><td>Cumulative Preventive Care Bonus</td><td></td><td colspan="4">For Pap smears, mammograms, childhood immunizations, flu shots and Colorectal Cancer Screening on formally enrolled patients.</td></tr>
<tr><td>Diabetes Management Incentive (Q040)</td><td colspan="5">Annual $60/patient for co-ordinating, providing and documenting all required elements of diabetic care.</td></tr>
<tr><td>After Hours and Enhanced After Hours</td><td></td><td>One 3-hour block of after-hours coverage per week (Must agree to provide within six (6) months of signing contract or contract ends).</td><td colspan="3">
<table>
<tr><th>Number of Physicians in a Group</th><th>Total Number of After-Hours Service Blocks</th></tr>
<tr><td>3</td><td>3</td></tr>
<tr><td>4</td><td>4</td></tr>
<tr><td>5-9</td><td>5</td></tr>
<tr><td>10 – 19</td><td>7</td></tr>
<tr><td>20 – 29</td><td>8</td></tr>
<tr><td>30 – 74</td><td>10</td></tr>
<tr><td>75 – 99</td><td>15</td></tr>
<tr><td>100 – 199</td><td>20</td></tr>
<tr><td>200 +</td><td>25</td></tr>
</table>
* There is an exemption if > 50% of the group provides emergency, anesthesia coverage, or obstetrics coverage. Northern and Rural FHN and FHO groups that are required to have 50% of their physicians maintain active inpatient hospital privileges do not have to provide more than five (5) after hour blocks per week.
</td></tr>
<tr><td>House Call Bonus and Premium</td><td></td><td></td><td colspan="3">In addition, a new bonus is created that will pay physicians in the CCM, FHG, FHN and FHO models a 20% premium on the value of claims for house visits, and full fee-for-service value in the FHO model, in excess of the level C threshold (17 distinct patients and 68 or more encounters) if at least 75% of the house calls performed in the year were for Complex House Call Assessments (A900A).</td></tr>
</table>

Incentives / Premiums	Fee for Service (FFS)	Comprehensive Care Model (CCM)	Family Health Group (FHG)	Family Health Network (FHN)	Family Health Organization (FHO)
Group Management and Leadership Payment				$1/enrolled patient/year (max $25,000)	
Heart Failure Management Incentive (Q050)		Annual $125/formally enrolled patient for co-ordinating, providing and documenting all required care of heart failure patients.			
Newborn Care Episodic Fee				Q014A: $15.05 paid to physicians for each of up to eight (8) A007 (well baby care) visits in the first year of life for enrolled patients.	Q015A: $13.99 paid to physicians for each of up to eight (8) A007 (well baby care) visits in the first year of life for enrolled patients.
Unattached from Hospital Fee (Q023)		A one-time fee of $150 payable to physicians who roster acute care patients previously without a family physician, following discharge from an inpatient hospital visit. The patient must be rostered by the physician within three months, and primary care services provided. This fee is not payable in addition to existing "new patient fees."			
Out of Office Bonus	Level 'A' & 'B' from any of: Home Visits, Palliative Care, Labour and Delivery, and Long Term Care.	Levels 'A', 'B', 'C' and 'D': Home Visits, Palliative Care, Labour and Delivery, and Long-Term Care. Payment is dependent on service level. Up to $8,000 for Home Visits, $5,000 for Palliative Care, $8,000 for Labour and Delivery, and $5,000 for LTC Visits.			
Smoking Cessation Counselling Fee and Smoking Cessation Add-on Fee (Q042)		Available to physicians who initiate dialogue with their enrolled patients who smoke, and provide dedicated subsequent counselling sessions. 2/year, $7.50. Add on to K039.			

Ministry of Health and Long-Term Care Unilateral Action

Eliminated Fee Codes as of June 1, 2015

- Q013A 'New Patient Fee'
- Q033A 'New Graduate New Patient Fee'
- Q054A 'Mother and Newborn Fee'
- Q055A 'Multiple Newborn Fee'
- Q056A 'HCC Upgrade Patient Status'
- Q057A 'HCC Greater than Three Months Fee'
- Q555A 'CME Main Pro C'
- Q556A 'CME Main Pro M1'
- Q557A 'CME Other'

For patient enrolments effective June 1, 2015 or later, the following Per Patient Rostering fees will be reduced to pay at zero dollars:

- Q200A 'Per Patient Rostering Fee'
- Q201A 'GHC Per Patient Rostering Fee'
- Q202A 'LTC Per Patient Rostering Fee

Physicians should continue current enrolment processes and submit these fee codes in order to manage patient enrolment, but there will no longer be any payment associated with these fee codes.

Resources for Members

If you have any Primary Care questions, please contact the following:
Kate Damberger, OMA Economics, Research & Analytics Department. E-mail: kate.damberger@oma.org
Adam Farber, OMA Legal Services Department. E-mail: adam.farber@oma.org
Voytek Roszuk, OMA Negotiations and Implementation Department. E-mail: voytek.roszuk@oma.org

For additional information related to the OMA-MOHLTC Agreement, please visit: https://www.oma.org/Member/Resources/AgreementCentre/Pages/default.aspx
For additional information applicable to physicians in Primary Care models, please visit: https://www.oma.org/Member/Resources/PrimaryCareModels/Pages/default.aspx