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FACT SHEET

Ministry of Health and Long-Term Care
Primary Health Care Branch

PRIMARY CARE PHYSICIAN COMPENSATION AND COMPLEX PATIENTS

May 2014

Provision of Comprehensive Care

Comprehensive Care is a key component of Alternative Funding Arrangements (AFAs) under which the majority of primary care physicians in Ontario practice and are compensated. Comprehensive Care assumes that the care is part of an on-going process that factors in the patient's family and social context. It includes the creation, management and maintenance of an appropriate medical record managed by the primary health care provider.

Comprehensive Primary Care, as defined in the various primary care Alternative Funding Arrangements (AFAs), includes the following services, several of which may be required in the care for complex patients:

- Health Assessments
- Diagnosis and Treatment
- Primary Reproductive Care
- Primary Mental Health Care
- Primary Palliative Care
- Support for Hospital, Home and Long-Term Care Facilities
- Service Co-ordination and Referral
- Patient Education and Preventative Care
- Pre-Natal, Obstetrical, Post-Natal, and In-Hospital New Born Care

Compensation for Comprehensive Primary Care

Compensation for the provision of comprehensive primary care services, including services required by complex patients, takes various forms under current primary care AFAs:

- Capitation - For primary care physicians in a capitation-based payment model (Family Health Network and Family Health Organization) the Base Rate payments are age and sex adjusted and the "basket of services" (codes included under the capitation payment) includes many of the activities required for the care of complex patients.

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- Enhanced Fee for Service - For primary care physicians in the enhanced fee-for-service model (Family Health Group), physicians are compensated through a Comprehensive Care Premium (10%) on the value of specific Schedule of Benefits codes for services rendered to enrolled patients, including those required by complex patients.

- Salary – For primary care physicians in the various salaried models (RNPGA, GP Focused Practice, etc.) the salary payment under the primary care AFA compensates for the provision of comprehensive primary care services, including care for complex patients.

- Comprehensive Care Capitation – All physicians participating in a primary care Patient Enrolment Model (PEM) receive a comprehensive care capitation payment (approximately $3 per month for each enrolled patient) that provides physicians with additional payment for ensuring comprehensive care is delivered to their enrolled patients, including complex patients.

- Acuity Modifier - The 2012 Physician Services Agreement set aside $40 Million for a premium for the acuity of patients enrolled to a primary care physician. This remunerates physicians for providing care to their most complex patients.

- Bonus and Premiums - Physicians in the various primary care models are provided with add-on bonuses and premiums for enrolling and providing care for patients that are of greater complexity – e.g. enrolment premiums for accepting unattached patients (Health Care Connect complex vulnerable fee and top up payment, FOBT new patient fee, unattached patient fee discharge from hospital and mother and newborn fee) and special premiums for targeted service provision (serious mental illness, diabetes management, congestive heart failure management, hospital services premium and Out of Office premiums for palliative, home visits and LTC).

Collaboration

Care for complex patients often requires physicians to collaborate with others to ensure complex patients are receiving the most appropriate services at the right time and in the right place.

Compensation schemes currently exist to support collaboration, as defined in the common elements of insured services set out in the Schedule of Benefits. Unless there are specific services listed in the Schedule of Benefits, the funding of insured services, whether from the Schedule solely or through an alternative funding arrangement includes, as a common element, gathering information about the patient from appropriate sources and sharing information with other health professionals.

Below are some examples of existing compensation schemes aimed at enabling collaboration to support care for complex patients:

Case Conferences

There are a number of Case Conference codes ($31.35 per unit) listed in the Schedule of Benefits. A case conference must be pre-scheduled, a minimum of 10 minutes and:

- must be conducted by personal attendance, videoconference or by telephone
- must involve at least 2 other participants who meet the eligible participant requirements as indicated in the specific listed case conference services; and
- at least one of the physician participants is the physician most responsible for the care of the patient.

Case conference fee codes are specific to certain types of patients in specific settings. Please refer to pages A29 – A34 in the April 2013 Schedule of Benefits for complete details. Additional information is to be found in each AFA agreement, which will identify whether these services are included codes within each primary care funding model.

Telephone and Email Communications

The Schedule of Benefits has a telephone consultant code for physician to physician communication. Physician to physician telephone and email consultation are services where the referring physician, in light of his/her professional knowledge of the patient, requests the opinion of another physician (the "consultant physician") by telephone or email who is competent to give advice in the particular field because of the complexity, seriousness or obscurity of the case.

This telephone service includes all services rendered by the consultant physician to provide opinion/advice/ recommendations on patient care, treatment and management to the referring physician. The consultant physician is required to review all relevant data provided by the referring physician.

- K730 – Telephone Referring physician ($31.35)
- K731 – Telephone Consultant physician ($40.45)[1]

Physician to physician e-consultation is similar to telephone consultation but where the both the request and opinion are sent by electronic means through a secure server. This service is only eligible for payment if the consultant physician has provided an opinion and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.

This service includes all services rendered by the consultant physician to provide opinion/advice/ recommendations on patient care, treatment and management to the referring

[1] Both of these codes are included codes in the Family Health Network and Family Health Organization models, and are also included codes under the various primary care salaried models.

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- K738 – e-consultation Referring physician ($16.00)
- K739 – e-consultation Consultant physician ($20.50)[2]

Hospital Discharge

A timely primary care appointment following hospital discharge is often required by patients with medical complexity and is an activity that requires collaboration and/or communication between the hospital and the primary care physician. An add-on fee is available for the first visit of a patient who has been recently discharged from hospital (E080 -$25.00), which can be used in conjunction with other billing codes specific to chronic conditions.

Chronic Disease Management

Complex patients often have multiple chronic conditions, which require on-going management by a primary care physician and, often, a range of other health care providers. The Schedule of Benefits lists over 5,000 fee codes. While not every specialized visit has a dedicated fee code that can be used, there are some specific chronic conditions that have their own fee codes. These codes are time based and must meet the time keeping and minimum requirements as listed on page GP48.

- K022 – HIV primary Care ($62.75 per unit)
- K037 – Fibromyalgia/Chronic Fatigue Syndrome ($62.75 per unit)
- K023 – Palliative Care Support ($62.75 per unit)
- K028 – STD Management ($62.75 per unit)
- K029 – Insulin Therapy Support ($62.75 per unit)
- K030 – Diabetic Management Assessment ($39.20)

There are other codes that are specific to certain conditions that are not time based, such as:

- Q040 – Diabetic Flow Sheet, once per year ($60.00)
- K039 – Smoking Cessation Follow Visit (after E079) ($33.45)

Access Bonus

A common concern expressed by physicians practicing in the capitation-based primary care models (Family Health Networks and Family Health Organizations) is that referral of their enrolled complex patients to other family physicians in the community for specialty care negatively impacts their Access Bonus payment.

[2] Neither of these codes are included codes under the Family Health Network and Family Health Organization models, but are included codes under the various primary care salaried models. Please refer to your primary care AFA agreement.

Under the capitation-based models, the Access Bonus payment is reduced every time a rostered patient sees another family physician outside the enrolling group for “in-basket” services. This payment element is intended to encourage physicians in these models to provide the full scope of comprehensive primary care services to their enrolled patients.

General Practitioners that practice in a focus area are eligible to apply for an exemption from impacting the Access Bonus. The GP Focused Practice Designation was established in order to recognize specialized services provided by GP Focused Practice physicians and the possible impact of those services on the Access Bonus of physicians participating in capitation-based primary care models. The 2008 *Physician Services Agreement* expanded the focused practice self-identification process which was originally outlined in the 2004 *Physician Services Agreement* and the 2007 *Reassessment Agreement*.