October 11 2018

Arbitration Position of the Ministry of Health and Long Term Care for Primary Care

A) RECALIBRATE BASE CAPITATION RATES FOR FHOs

Adjust the base capitation rate paid to FHO physicians for enrolled patients to reflect the changes in volume of services and changes in demographics since the 1999 base year.

The impact of recalibration to the foundation principles behind the calculation of an appropriate capitation rate would result in a change from $165.41 to $120.89 per enrolled patient based on the current basket of included services. This estimate is based on the 2015-16 OHIP utilization and population statistics.

Effective April 1, 2019, reduce the base capitation rate paid to FHO physicians by 33.3% of the resulting gap between the current capitation rate and the appropriate, recalibrated capitation rate (e.g. reduced by $14.84 per enrolled patient based on the current basket of included services).

B) INCREASE TO FHO MANDATORY GROUP SIZE

By April 1, 2019 all PEM groups must be comprised of at least six physicians. This will allow for appropriate coverage and access for patients weekdays, evenings, weekends, and during holidays or short term leaves of absence.

For groups in smaller communities that cannot achieve six person groups, special consideration can be negotiated with the Negotiations Branch of the ministry.

The ministry recognizes that all physicians in a FHO may not be on the same geographic site. However they should be relatively proximal to facilitate meaningful patient access. All sites must also offer cross coverage to each other and have a shared electronic medical record (EMR). They must offer shared after-hours care for patients rostered to that FHO and coverage for any physician leaves regardless of site.

C) DAYTIME HOURS REQUIREMENT

For an average roster size of 1,300 patients, groups will provide nine (9) units of care sometime between 0600 and 1700 daily, Monday to Friday. A unit of care is four (4) hours.

During the four hour unit it will be expected that on average services will be provided, face-to-face, to 12 patients.

Since this is a group endeavour, the averaging of the services provided to patients will be measured quarterly (over a three month period) for the entire FHO group.

For FHO's where the average roster size is either above or below 1300 patients, the parties should establish appropriate pro-rated changes to the required daytime Monday to Friday hours.

Also, to ensure that patients have access to the hours of service of their physician's group, the hours of service will be posted in the office, on-line and shared with the Local Health Integration Network (LHIN).

D) FHO AFTER HOURS REQUIREMENT

For an average roster size of 1,300 patients, FHO groups will provide at a minimum one three hour unit of evening care Monday to Friday and three hour units every third Saturday or Sunday, sufficient and convenient to serve enrolled patients.

The required number of units will be prorated either up or down depending on the total group roster.

E) END THE PATIENT ENROLMENT MODEL (PEM) AFTER-HOURS EXEMPTION

FHN and FHO groups will no longer be given an exemption from providing after-hours to enrolled patients. The ministry will continue to pay all capitation payments and physicians will fulfill the contractual obligations while meeting the obligation for evening, weekend and holiday coverage as required in the agreement.

Physicians can continue to undertake other clinical work but it will not obviate the group's requirements for the after hour coverage in the contract.

F) REQUIREMENT FOR PROMPT ACCESS TO APPOINTMENTS FOR ACUTE CONCERNS

Effective April 1, 2019, where a patient's FHO physician is not available during weekday hours, the FHO will provide a patient presenting with a time-sensitive condition the option of seeing another FHO physician (whether face to face or virtually as clinically appropriate), or as clinically appropriate an allied health provider affiliated with the FHO, on the same or next day, or an after-hours clinic that day or the following day.

FHOs are encouraged to consider including the following illustrative examples as time sensitive conditions:

a) significant new or worsening pain (including pain caused by recent injury),
b) new onset or change in symptoms of infection including fever, rashes, gastrointestinal changes, urinary changes, respiratory changes,
c) exacerbation in chronic conditions (for example back pain, heart disease, lung disease or abdominal or gynecological disease),
d) concerns regarding pregnancy and newborns and infants,
e) decompensation in mental health or substance use, or
f) time sensitive prescriptions that cannot be managed in other ways.

but would not include:

a) annual health exams and preventative screening visits,
b) completion of forms (for example tax disability, insurance, school trips/camp), or
c) routine follow up of chronic physical and mental health conditions.

FHOs are encouraged to provide education and training to staff with responsibility for setting appointments related to these time sensitive examples.

G) ADJUST THE MAXIMUM SPECIAL PAYMENT (MSP) TO REDUCE OUTSIDE USE (FHO & FHN)

Effective April 1, 2019, amend the primary care FHN and FHO contracts to change the Maximum Special Payment provision (Access Bonus) to recover negative access bonus payments dollar for dollar.

H) INCLUSION OF EMERGENCY DEPARMENT USAGE IN OUTSIDE USE (FHO & FHN)

Effective April 1, 2019, recover the Emergency Department Best Managed Elsewhere (EDBME) services from the Access Bonus Payment at a service value equal to the A007 and A888 when the ED service is rendered during regular office hours Monday through Friday, 8am – 5pm.

There is no change the current listing of the limited service codes currently considered.

I) QUALITY IMPROVEMENT PLANS

Extend the requirement for all primary care physicians to participate in quality improvement activities. This will include the following supports for those in the FHN and FHO:

- All FHNs and FHOs to complete an annual QIP and submit it to HQO similar to other current primary care models such as CHC
- OMA and HQO to work together to develop a QIP model that can be utilized by other primary care models such as FHN, FHG and FFS.
- Each FHN and FHO group should have members (including physicians) with skills in quality improvement (such as provided by the Improving & Driving Excellence Across Sectors (IDEAS) Advanced and Foundations training program)
- Access to data management/ EMR support (such as the Quality Improvement Decisions Support Specialists currently provided to FHTs)
- All individual physicians, regardless of model should receive the HQO Primary Care Practice Improvement Reports. These provide standardized metrics, and audit and feedback supports including practice- and group-level data on these metrics.

J) ADD A888A (EMERGENCY DEPARTMENT EQUIVALENT), G590A (INFLUENZA AGENT), A002A (18 MONTH WELL BABY VISIT) TO THE BASKET OF INCLUDED CODES

Effective April 1, 2019:

A888A to be included as an "in basket"/included Fee Schedule Code, eliminating incentive for its use. The A888A would be paid at zero dollars with the Blended Fee for Service premium paid at 15% of the fee value and would continue to be billed in conjunction with the Q012 premium paying at 30% of the fee value.

A002A to be included as an "in basket"/included Fee Schedule Code. The A002A would be paid at zero dollars with the Blended Fee for Service premium paid at 15% of the fee value.

G590A to be included as an "in basket"/included Fee Schedule Code. The G590A would be paid at zero dollars with the Blended Fee for Service premium paid at 15% of the fee value.

K) Eliminate Cumulative Preventative Care Bonus

End the Cumulative Preventative Care Bonus effective April 1, 2019.

Below is a list of the current bonuses and premiums, by category with expenditure amounts for the 2015-16 fiscal year:

Cumulative Preventive Care Bonus - (FY15-16 $55.0M)

1. Influenza Immunization– target population, patients over age 65
2. Pap smear – target population, women between the ages of 35 and 70
3. Mammogram – target population, women between the ages of 50 and 70
4. Childhood Immunization – target population, patients between ages of 18 months and 2 years
5. Colorectal Cancer – target population, patients between the ages of 50 and 74 years

Colorectal Cancer Screening Premiums

1. FOBT Distribution – All models ($2.947M)
2. FOBT Completion – CCM/FHG/GP Only ($0.031M)

L) Discount Applied to Services Billed Outside of Enrolling Group

A discount of 25% be applied to the fee value of all services provided to PEM enrolled patients when the service is provided by a physician outside the enrolling group.

The discount to be implemented at the start of the final year of the agreement and ongoing.