

Family Practice Renewal Committee (FPRC) Policy on the Blended Capitation Group Model

The FPRC Policy on the Blended Capitation Group Model outlines FPRC’s policy and procedures for the Blended Capitation Model which is the payment model for medical practitioners licensed to practice family medicine in Newfoundland and Labrador that provides a capitation payment for providing a “Basket of Services” to each attached patient, and a partial fee-for-service payment for each service provided within the MCP Medical Payment Schedule to an attached patient (the “Model”). The “Basket of Services” means the set of core Insured services provided by participating physicians for attached patients and reflects the typical activities of a family physician (non-specialized) in an office-based setting. The Basket of Services is set out in Appendix B to Schedule R of the Memorandum of Agreement.

These policies and procedures comply with Schedule R to the Memorandum of Agreement among the Newfoundland and Labrador Medical Association (NLMA) and the Government of Newfoundland and Labrador dated May 3, 2022 which may be renegotiated or amended from time to time upon the mutual written agreement of the NLMA and the Government. FPRC may accordingly introduce new policies from time to time. This policy document is designed to help you learn more about the Model. This policy document should be retained for reference. All rights and obligations are determined in accordance with the MOA, not this policy.

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1. Objectives of the Model

The objective of the Model is to contribute to a health care system in which all residents have timely access to excellent team-based primary medical care that provides comprehensive and continuous primary care to patients attached to a Group of physicians established for the purpose of providing care under the Model, the eligibility requirements of each member of which have been confirmed as being met by the FPRC and the constitution of which Group has been confirmed by the FPRC ("Group").

There must be appropriate accountability for the public funds expended under the Model and the management and administration of the Model by the FPRC must include, through the use of appropriate performance metrics, the continuing assessment and evaluation and participation and operation of the Group in providing care pursuant to the Model.

A Group must be committed to the provision of comprehensive and continuous primary healthcare services across the life span of their Patients, based on patient needs.

2. Memorandum of Agreement and Schedule "R"

These policies reflect the provisions of Schedule R to the MOA, but do not form part of the MOA. To the extent of any inconsistency among the provisions or interpretation of these policy provisions and those of the MOA, the latter shall prevail.

3. Voluntary Participation in the Model

A Physician's participation in the Model is voluntary. At their discretion, but in accordance with the discontinuance policies and procedures of the FPRC, they may individually or collectively cease participation in the Model.

An acceptance date into the model will be established which is the agreed date on which the Group is confirmed by the FPRC as being eligible to practice under the Model or, in the case of a medical practitioner joining an already established Group, the date established by the Group, the Physician and the FPRC as being the date of commencement of practice within the Group.

4. Physician Requirements

Each physician that wishes to participate in the Model shall maintain registration with the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) and is required to be a member of a Family Practice Network (FPN), where one exists in their geographic region. A FPN means the initiative created and supported by the FPRC to organize medical practitioners at the sub-regional or regional level in order to address common health care goals in their communities. Each FPN is a not-for-profit corporation constituted by the medical practitioners within their sub-region or region.

5. Introduction of the Billing System

The Minister of Health and Community Services (the Minister) will confirm the date on which the provincial systems are operational for all purposes of the Model, including the process of capitation and other payments to Physicians and the collection and recording of all necessary Patient and service-related data.

Pursuant to Schedule R, the billing system commencement date will be no later than April 1, 2024.

Initial access to and utilization of the billing system will be limited to no more than 75 physicians, such physicians to be selected by the FPRC.

Access to and utilization of the billing system will be available to all Groups no later than July 1, 2024. Until a Group starts on the new billing system, the Group is to continue billing FFS in the normal course.

6. Patient Attachment and Rostering

A roster means the listing of patients who are attached to a Physician in accordance with the rostering provisions of Article 3.4 of Schedule R to the MOA (the "Roster"). Attached means there is a formalized, continuous relationship between a patient and a Group.

In order to add a patient to the Roster, the Group shall follow and comply with the patient enrollment procedures as may be prescribed by the FPRC from time to time. Upon addition to the Roster the patient is deemed to be "attached".

The Physician may not refuse to accept a Patient for placement on, or remove a patient from their Roster, because of the Patient's healthcare status or need for health services.

On a regular basis as may be required by the FPRC and/or the provincial payment system, the Physician will confirm the total number of patients currently attached and, since the date of last confirmation, the number of patients newly attached and the number of patients removed from the Roster. A patient will be deemed to be removed from a physician's roster and no longer attached to a physician immediately upon: admission to a Long Term Care Facility, meaning a publicly-operated long-term care facility providing on site professional health and nursing services; the patient's death; or removal from the Roster by the physician.

The entitlement of the physician to any form of capitation payment ceases on the deemed removal of a patient from the physician's Roster. Should any such payment be made to the physician subsequent to the removal of the patient from the Roster, such payment will be adjusted to future payments by the provincial payment authority.

7. Roster

The Group will establish and maintain a Roster of all patients who become formally attached to a particular physician within the group. The Roster will contain such information as may reasonably be required by the Minister, including the name of the physician expected to form a continuous care-related association with the patient. Once the name of a patient and associated physician is entered in the Roster, the patient is deemed to be attached to the physician for the purposes of the Model.

The maximum number of attached patients for a member of the Group is 2400.

Nurse Practitioners and Registered Nurses

Should a Nurse Practitioner (NP) or Registered Nurse (RN) be employed with or contracted by the Group to provide team based primary care within the Group, up to 900 patients per NP and up to 600 patients per RN may be added to the total Roster of the Group, provided that, unless otherwise approved by the FPRC, the total Roster addition attributed to NP/RN shall not exceed 3000.

For the purposes of billing, the allocation and attachment of patients so added to the Roster shall, as between the individual physician members of the Group, be as agreed by those members.

Subject to the roster limitation, the number of NP/RNs that may be employed or contracted by the Group is not limited.

If a patient is added to the Roster through a NP, the NP will assume the role of most responsible provider for the patient which is to be established in a separate agreement existing between the NP and the patient (the "Most Responsible Provider"). Although a patient is attached to the physician for billing purposes, the patient remains the legal responsibility of the NP for all medical and treatment services.

The Group shall promptly notify the FPRC, or an appropriate alternate contact, when a NP or a RN joins a Group and advise which physician or physicians the extra allocation(s) of rostered patients will be assigned for billing purposes. Further, the Group shall promptly notify the FPRC, or an appropriate alternate contact, of the date when a NP or RN departs a Group as the extra allocation(s) of rostered patients associated with the NP or RN can be removed from the roster cap.

If a NP leaves a Group permanently, the patient(s) will be de-rostered from the Group:

1. from the relevant physician for purposes of capitation payments; and
2. from the NP as Most Responsible Provider.

In the event the NP carries patient(s) to an alternate blended capitation group, the patient(s) may be re-rostered under the new blended capitation group. Alternately, the de-rostered patient(s) may be re-rostered to a physician or a different NP within the existing group, which is to be arranged at the discretion of the relevant medical providers.

8. Patient Services

The Group must be committed to using its best efforts to provide its Roster of patients availability and timely access to excellent team-based primary care. The Group will establish, based on the primary care needs of its Roster, a schedule for the regular weekly availability of non-emergency priority care. This does not mean that every physician within the Group must work Monday through Friday, 9 am to 5 pm. Rather, it means that regular availability must be established each week in relation to Roster size, with recognition that physicians may set aside time for other medical activities, administrative activities, or have a part-time practice.

Services may be provided virtually or in-person at the discretion of the provider in accordance with the College of Physician and Surgeons of Newfoundland and Labrador's Standard of Practice (SoP): Virtual Care (2023), as may be amended or replaced by the College of Physicians and Surgeons of Newfoundland and Labrador.

Billing for these services shall be in accordance with established MCP rules for submitting accounts and collecting payments, which is in accordance with the *Medical Care and Hospital Insurance Act*, SNL 2016, c. M-5.01 and applicable regulations.

The Group will provide after-hours clinics for attached patients outside the hours of 9 am – 5 pm, Monday to Friday on the basis that in each quarter the hours of such clinics shall be at least 2.2 hours per 100 patients on the total Group Roster, and further provided that, regardless of Roster size, a minimum of 3 hours of after-hours clinics per week is provided. Quarter shall mean the 3-month period commencing April 1, July 1, October 1, or January 1 of each calendar year.

Examples:			
Number Attached Patients	Hours per Quarter (13 weeks) Formula: Roster size/100x.2.2	Average Hours per week	Minimum Hours per week
3600	79	6.1	3
4000	88	6.8	3
6000	132	10.1	3
7200	158	12.2	3

All physicians in the Group will participate in after-hours service, but the distribution of such hours between physicians may take into consideration the regular, ongoing provision of services such as hospital ER coverage, anesthesia services, obstetric services, long-term care services and other relevant factors.

Policies and rules will be further developed by the FPRC regarding patient services.

The after-hours requirement may be modified according to the amendment of the MOA effective July 31, 2023 in relation to Article 3.5(c.1), the after-hours expectations effective September 1, 2023 up to August 31, 2025 are as follows:

1. The Group that provides regular, ongoing services such as hospitalist services, primary care services for unattached patients, hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services may distribute their after-hours service under the Model to the Group's Nurse Practitioner (NP), where the Group has hired a NP;
2. The Group that provides regular, ongoing services such as hospitalist services, primary care services for unattached patients, hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services, where the Group has not hired a NP, may be exempted from the Model's after-hours requirement in subsection 3.5(c) of Schedule R, on application to the FPRP and on decision of the FPRP in accordance with the FPRP's policies and rules.
3. Subsection 3.5(c.1) shall only be in effect for the transition period September 1, 2023 and August 31, 2025 and only so long as the physician provides at least two hours of the types services described in 1 and 2 to NLHS for every one hour of after-hours service under the Model redistributed/exempted; and

4. Where a physician member of a Group does not provide the type or duration of services to the NLHS as described in 1-3, that member of the Group is not eligible for redistribution/exemption of after-hours service expectations as set out in subsection 3.5(c) of Schedule R. The physician will provide after-hours service pursuant to the 3.5(c) formula under Schedule R, **but prorated to the number of patients who are attached to them** (emphasis added).

For the purpose of interpreting the Article 3.5(c.1) amendment, the minimum after-hours service requirement under the Model will be adjusted in accordance with the exemptions set out in 1-3 for remaining participating physicians when a Group falls below 3 Physicians.

Locums

Where reasonably possible, services to patients will be provided by the physicians in the Group rather than by locums or subcontractors.

The hiring and payment of locums and the terms of any agreements with locums are the responsibility of the Group and shall in no way be considered the responsibility of the Minister.

Locum physicians will submit all billings for services rendered through the billing number of the locum physician, but with the payment for such services assigned to the Group or individual Physician as the case may be. Such payments will be considered as a Fee for Service (FFS) payment for in-basket services delivered to attached patients, and FFS payment for out-of-basket services delivered to all Patients, or as in-basket services delivered to non-attached patients in accordance with Article 3.10 of Schedule R of the MOA.

9. Group Composition

A Group must consist of at least 3 physicians. Consistent with Schedule R, when a Group falls below 3 Physicians, the goal of the Group and the FPRC is to re-establish the minimum number of Physicians in a reasonable period. It is expected that the Group will make diligent efforts to recruit a new physician(s) to the Group as quickly as possible. The FPRC will review the Group's efforts every 12 months to determine if a reasonable effort has been made. The FPRC's determination will take into account the general conditions for recruitment of Physicians within the region and the province as a whole.

The FPRC will not terminate a Group if the Group is making reasonable efforts to recruit the minimum number of Physicians. The FPRC will support the process by promoting the opportunities of the Blended Capitation Model to other physicians and identifying opportunities for Group mergers. The final decision on the physicians who will be part of a Blended Capitation Group – whether through recruitment or a merger with another Group – will be that of the Group Physicians.

During the period of time in which the Group continues to practice with fewer than 3 Physicians, the Group, in consultation with the FPRC, is to continue to provide services to all attached patients of the remaining Physicians as per Schedule R of the MOA; consistent with the foregoing, the FPRC will consider, at the request of the Group, a proportionate reduction in the after-hours service of the Group for this time and any extension of time as approved by the FPRC, but in any event, the remaining Physicians are to provide a minimum of 3 hours of after-hours clinics per week.

In the event a termination of a Group occurs, the Physicians will transition back to Fee for Service (FFS) in accordance with Schedule R.

The FPRC may update its rules and processes regarding transitions in Group composition from time to time.

10. Remuneration

Physicians who have a private primary care practice located in a health authority facility that is part of Newfoundland and Labrador Health Services (NLHS) shall, for the purpose of FFS billings, bill office codes for services provided in their private primary care practice and facility-based codes for services provided as part of their NLHS services.

As of the commencement date of the billing system and, subject to the provisions of the test group, each physician will receive from MCP:

1. a base capitation payment for each attached patient, adjusted for each patient by the complexity modifier table attached to Schedule R;
2. FFS payments at 25% of the rate in the MCP Payment Schedule for in-basket services provided to attached patients; and
3. FFS payments at 100% of the rate in the MCP Payment Schedule for all other services, including services provided to patients not on the Roster of the Group.

As of October 11, 2023, the base capitation rate will be \$186.29 per attached patient. The base capitation rate, and the complexity modifier, may be adjusted from time to time as mutually agreed in writing by the Government and the NLMA.

Following the end of the two-year Income Floor period, the annual FFS billings of a physician for in-basket services provided to patients are who not attached patients is capped at \$56,000. For greater certainty, there is no limit to FFS billings of a physician for out-of-basket "services" to rostered and non-rostered patients.

Capitation payments do not include payments received by a physician for services to patients outside the normal in-basket private setting, including such payments as emergency department payments, the rural retention bonus, CMPA reimbursement, obstetrical bonus, on-call payments, surgical assist payments, academic payments, and other sessional payments and/or employment income from NLHS, from third parties, or such other categories of excluded payments as may be added by the FPRC.

11. Income Floor

Commencing on the acceptance date into the Model, each member of the Group will for a period of two years be entitled to receive a guaranteed minimum level of compensation provided to physicians participating in the Model in accordance with Article 3.12 of Schedule R of the MOA (the "Income Floor").

Prior to acceptance into the Model, each physician and the FPRC will reach an agreement on what the average annual income of each member of the Group for the purposes of the Income Floor will be, which shall be acknowledged in writing by each physician of the Group.

The Income Floor for physicians accepted into the Model, who have been in practice greater than two years, will be calculated by averaging the physician’s billings from two recent, representative years of active practice in Newfoundland and Labrador prior to application to the Program, excluding periods of time when the physician was away from their practice, such as time on parental leave.

The Income Floor for physicians without a two-year billing history and physicians who do not have an established patient panel, will be at Step 1 from the MOA, or for a physician transitioning from a salaried position, their current Step, of the Salary Scale for family physicians, adjusted to the proportion of FTE of comprehensive primary care the physician commits to provide in accordance with the table below, plus an additional 30% in recognition of overhead expenses, and an additional 10.9% payable in year one of the Income Floor period. The amount of FTE of comprehensive primary care that will be required to qualify for payment under Article 3.12(b) of Schedule R will be determined according to the number of three-hour community medicine blocks provided per four-week period.

FTE Adjustment Factor	Minimum number of three-hour community-based primary care blocks per week, on average over a four-week period
1.0	9
0.9	8
0.8	7
0.7	6
0.6	5
0.5	4

The Income Floor calculations for physicians without a two-year billing history will be calculated as follows:

Income Floor Calculations for Physicians Without a Two-Year Billing History			
Family Physician Salary Scale, 2017-2023 MOA	Step 1	Step 2	Step 3
		\$ 198,724	\$ 206,911
FTE	1	1	1
Income Floor Amount (by FTE)	\$ 198,724	\$ 206,911	\$ 215,097
30% - Recognition of overhead expenses	\$ 59,617	\$ 62,073	\$ 64,529
10.9% - additional payment in year one of Income Floor period	\$ 28,159	\$ 29,319	\$ 30,479
Year One Total	\$ 286,500	\$ 298,304	\$ 310,105
Year Two Total (if billing system not ready Year One Total is carried over)	\$ 258,341	\$ 268,984	\$ 279,626
FTE	0.9	0.9	0.9

Income Floor Amount (by FTE)	\$ 178,852	\$ 186,220	\$ 193,587
30% - Recognition of overhead expenses	\$ 53,655	\$ 55,866	\$ 58,076
10.9% - additional payment in year one of Income Floor period	\$ 25,343	\$ 26,387	\$ 27,431
Year One Total	\$ 257,850	\$ 268,473	\$ 279,095
Year Two Total (if billing system not ready Year One Total is carried over)	\$ 232,507	\$ 242,086	\$ 251,663
FTE	0.8	0.8	0.8
Income Floor Amount (by FTE)	\$ 158,979	\$ 165,529	\$ 172,078
30% - Recognition of overhead expenses	\$ 47,694	\$ 49,659	\$ 51,623
10.9% - additional payment in year one of Income Floor period	\$ 22,527	\$ 23,455	\$ 24,383
Year One Total	\$ 229,200	\$ 238,643	\$ 248,084
Year Two Total (if billing system not ready Year One Total is carried over)	\$ 206,673	\$ 215,187	\$ 223,701
FTE	0.7	0.7	0.7
Income Floor Amount (by FTE)	\$ 139,107	\$ 144,838	\$ 150,568
30% - Recognition of overhead expenses	\$ 41,732	\$ 43,451	\$ 45,170
10.9% - additional payment in year one of Income Floor period	\$ 19,711	\$ 20,524	\$ 21,335
Year One Total	\$ 200,550	\$ 208,813	\$ 217,074
Year Two Total (if billing system not ready Year One Total is carried over)	\$ 180,839	\$ 188,289	\$ 195,738
FTE	0.6	0.6	0.6
Income Floor Amount (by FTE)	\$ 119,234.40	\$ 124,147	\$ 129,058
30% - Recognition of overhead expenses	\$ 35,770	\$ 37,244	\$ 38,717
10.9% - additional payment in year one of Income Floor period	\$ 16,896	\$ 17,592	\$ 18,288
Year One Total	\$ 171,900	\$ 178,982	\$ 186,063
Year Two Total (if billing system not ready Year One Total is carried over)	\$ 155,005	\$ 161,391	\$ 167,776
FTE	0.5	0.5	0.5
Income Floor Amount (by FTE)	\$ 99,362	\$ 103,456	\$ 107,549

30% - Recognition of overhead expenses	\$ 29,809	\$ 31,037	\$ 32,265
10.9% - additional payment in year one of Income Floor period	\$ 14,080	\$ 14,660	\$ 15,240
Year One Total	\$ 143,250	\$ 149,152	\$ 155,053
Year Two Total (if billing system not ready Year One Total is carried over)	\$ 129,171	\$ 134,492	\$ 139,813

The Income Floor for the first year of a physician's membership in the Group will be the annual average income plus a premium of 10.9%. In the event that the Model's billing system is not operational when a physician enters year two of the Income Floor period, the physician will continue to receive the 10.9% premium on a month to month basis until the billing system is ready, up to the end of their two-year Income Floor period.

12. Top-Up

If, in any one or more of the four six-month periods commencing on and following the acceptance date, a physician's billings under the Model, including billings for out-of-basket services and for non-rostered patients are less than the Income Floor for such six-month period, the physician will be entitled to receive from the Government a top-up payment equal to the amount by which the Income Floor amount exceeds the Model income. The calculation of the Model income will be made on the basis of the date and amount of accepted billings to the payment authority without regard to the date of receipt of payment.

13. Grants and Stipend

On the acceptance date of a newly-established Group, each member of the Group will be entitled to receive:

1. A transition grant from Government; and
2. A start-up grant of \$10,000 from the FPRC.

On the acceptance date of an individual physician who is joining an established Group, the physician will be entitled to receive from the Government a transition grant of \$11,250.

Each physician on their acceptance date will be entitled to receive from the FPRP an annual quality of care stipend of \$7,500 in recognition of the physician's participation in FPRP or practice-initiated quality programs, practice improvement and related professional development. Entitlement to the payment of this stipend will at all times be subject to the application of FPRP guidelines with respect to the professional development initiatives that will be considered as acceptable for purposes of the stipend. All grants and stipends will be prorated in the event of a Physician's departure from the Model.

14. Procedures Bonus

Each physician will be entitled to receive an annual procedures bonus as follows:

1. A Physician will be entitled to the bonus who bills \$1,200 of in-basket Procedures fee codes (as set out in Appendix B to Schedule R of the MOA) in a calendar year, with the \$1,200 measured according to 100% of MCP Medical Payment Schedule;
2. Bonus payment of \$2,500;
3. Procedures bonus is payable when the above billing threshold is achieved during the year.

15. Electronic Medical Record (EMR)

Electronic Medical Record (EMR) means the provincial Electronic Medical Record (EMR) program, administered through NLHS, and governed jointly by the NLMA and the Department of Health and Community Services (HCS). The Group is required to utilize EMR as a condition of acceptance into the Model.

Alternately, if the Group is not utilizing the provincial EMR, but using a different electronic medical records program, as of the acceptance date, the Group must commit to converting to the full utilization of the EMR in its practice within six months of the acceptance date. As of the acceptance date, the FPRC will pay to the Group the sum of \$30,000.00 to assist it in meeting the cost of the transition to the provincial EMR.

16. Measurement of Performance and Assessment of Model

The FPRC will on a continuing basis assess and evaluate the Model and accordingly will assess and evaluate the participation of the Group in the Model through the use of performance metrics, as specified below, and to be developed by the FPRC (the "Performance Indicators"). The FPRC will monitor the following Performance Indicators related to services provided by physicians and Groups:

- Percentage of same day or next day appointments available to attached patients;
- After-hours access provided to attached patients; and
- Relational continuity, meaning the ongoing therapeutic relationship between a physician, including their team, and an attached patient.

The FPRC will further develop definitions and guidelines for the Performance Indicators and will monitor and adjust the Performance Indicators as required. Additional Performance Indicators may be developed by the FPRC.

The assessment of the Performance Indicators will be based on EMR data or data from hospital information systems. New data gathering requirements that create additional work for physician practices will not be introduced unless approved by the FPRC.

The Group will permit access to its EMR data as may reasonably be required by the FPRC or NLHS for the purpose of the development and use of such performance metrics, compliance with Model requirements and evaluating the success or otherwise of the Model. Such evaluation will not include any assessment of the quality of care received by any particular patient.

Additionally, the Program will be comprehensively tested by the FPRC to identify risks, including those around cost escalation, and the FPRC will explore solutions to mitigate those risks. The FPRC will continually review the Program to update its rules and processes and to determine if modifications to the parameters of the Model are required.

17. Termination of Group or Physician

The objective of the Performance Indicators is to encourage continuous improvement and/or maintenance of accessibility and high-quality care.

If, based on its evaluation, the FPRC considers that the Group or a Physician in the Group is not maintaining accessibility or quality of care, consistent with the above objective, based on Performance Indicators, the FPRC will engage the Group or the Physician in the Group in a process of information exchange and performance improvement.

If following such engagement, the FPRC concludes that the necessary improvement has not been achieved, the FPRC may in its discretion terminate the Group or an individual Physician within the Group from participation in the Program.

If the FPRC is unable to reach a decision regarding termination of a physician or the Group, the FPRC will refer the matter to the Minister of Health and Community Services for a final decision. Following consultation with HCS representatives and NLMA representatives on the FPRC, the Minister will make a decision on termination of the physician or the Group.

Within 10 days of the Minister's decision, the NLMA may refer any dispute, controversy or claim arising out of or relating to the Minister's determination, including any question regarding the Minister's interpretation and application of Schedule R, to arbitration for final resolution in accordance with the *Arbitration Act*, RSNL 1990 c.A-14. The parties to the arbitration shall be the NLMA and the Minister and the costs of such arbitration shall be equally borne by the parties to the arbitration, unless otherwise ordered by the Arbitrator.

Notwithstanding that any party has provided notice of termination, the physician(s) are to continue to provide services to all attached patients. The physician(s) will be entitled, during such notice period, to be paid for the services performed.

Upon any termination, the physician(s) shall make such arrangements and provide such co-operation and assistance as may be reasonably expected of them and required to facilitate an orderly termination and the continued provision of health care services to attached patients without any interruption or delay. Upon termination, the party who delivered the termination shall notify attached patients that the physician(s) will no longer be providing services under the Model.