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.

FPRC Policy on the Model includes the following guidance:

Last Updated:

Policy	**Date**
Section 14. Grants and Stipend	Updated November 12, 2025
Section 13. Top-up	Updated April 29, 2025
Section 4. Acceptance Date	Added May 13, 2024
Section 16. Annual Quality of Care Stipend	Added May 13, 2024
Section 20. Discontinuance	Added May 13, 2024
Section 9. Patient Services	Updated May 13, 2024
Section 10. Group Composition	Updated May 13, 2024
Section 12. Income Floor	Updated May 13, 2024
Section 14. Grants and Stipend	Updated May 13, 2024
Section 15. Procedures Bonus	Updated May 13, 2024
Section 19. Termination	Updated May 13, 2024

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.

4. ***Acceptance Date***

The acceptance date into the Blended Capitation Program (i.e., the date the Group or a physician joining an established Group is eligible to practice under the Model) is the date the signed Letter Agreement and initialed Appendices A and B for each physician in a group are received by FPRP. When Blended Capitation Groups (BCGs) are issued letter agreements for review and execution, they have six months for at least three physicians within group to submit their signed letter agreements and initialed appendices to FPRP. After six months the letter agreements will be void.

All of the initial members of a group will have the same acceptance date. Please note that a physician's acceptance date may not be the date that they signed their individual physician's letter agreement. Physician's may request confirmation of their acceptance date by contacting the Blended Capitation Program Manager, Melissa Sullivan at msullivan@nlma.nl.ca.

The acceptance date is used to determine: i) when grants and stipends will be authorized for payment and ii) when physicians may be eligible for an income floor top-up payment (eligible physicians will be topped up 90 days after the first six-month period following acceptance and every 6 months thereafter).

5. ***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.

6. ***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.

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.

7. ***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 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;
- removal from the Roster by the physician;
- an expired MCP number (card);
- an invalid MCP card;
- federal incarceration;
- a patient has been rostered by another physician;
- or a physician's roster limit has been reached.

When a patient's MCP card expires, they will be automatically de-rostered from the Blended Capitation billing system and they will not be eligible for billing under BCM or FFS. When a patient is de-rostered from the BCM billing system, MCP will send a notification to the physician that their patient was de-rostered via an EMR message.

Once a patient's MCP card is renewed they can be re-rostered in the BCM billing system by resubmitting the Blended Capitation fee code in the EMR billing window (as done for initial rostering). To limit issues with expired MCPs, office staff are encouraged to check patient's MCP cards when appointments are booked and at check-in to ensure they are valid before care is provided and if the card is close to expiry to remind them to renew online.

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.

8. 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.

Over time, the majority of a physician's patients will likely become rostered. However, some patients may remain outside the roster. This is ok but physicians must fulfill their commitment under Schedule R to providing comprehensive and continuous care to all of their patients: Section 3.3 (a) of Schedule R states that all family physicians will be eligible for payment through the Model, provided they "commit to provide comprehensive continuous primary healthcare services across the life span of their patients, based on patient needs and responsive to documented needs of the geographic community they serve."

If a patient opts not to roster, the physician can continue seeing them and billing FFS (subject to Section 3.9 of Schedule R, "3.9 FFS Billing for Non-Rostered Patients"). After the two-year Income Floor period, the FFS limit per physician for in-basket services provided to non-rostered patients is $56,000. There is no limit for FFS billings for the provision of "out of basket" services for rostered and non-rostered patients."

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.

9. 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. After hours requirements start on the date the Blended Capitation Group is onboarded to the billing system.

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 pro-rated 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.

Leave

Please refer to Schedule R Section 3.5 for service expectations of physicians participating in the Blended Capitation Model.

Capitation payments are paid biweekly with the expectation that care is being provided to rostered patients. In the case of physician leave (e.g., vacation, professional development, medical, and parental leave), patient care should be covered by a locum or another member of the Blended Capitation Group (BCG). Blended capitation physicians taking parental leave are eligible for the NLMA Parental Leave Allowance.

Physicians taking leaves longer than 30 consecutive days and who have not arranged for another provider within their group or a locum to cover their patients' care will have their blended capitation payments paused during the period they are absent, from day 31 of leave until they return. Physicians are to notify FPRP in writing in advance of the dates of the leave period by submitting an Extended Leave Form.

Physicians are encouraged to develop a group governance agreement to outline, among other things, how leave will be managed by the group including whether locums or other group members will be engaged to cover patient care, an understanding of what patient care is to be covered, and how capitation and FFS payments for that care will be allocated.

The program acknowledges that there may be occasions when physicians are unable to arrange care coverage for their patients including instances of unplanned leave. In such cases, the physicians should notify FPRP as soon as practicable to discuss their circumstances and to minimize payment impacts. In these instances, please email the Blended Capitation Program Manager, Melissa Sullivan, at msullivan@nlma.nl.ca.

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.

10. Group Composition

A Group must consist of at least 3 physicians.

In the event a physician joins an established Blended Capitation Group of three physicians who have already submitted their signed Letter Agreements, a declaration reflecting the revision to group membership will be prepared for all members to sign. The new member will also be asked to sign a Letter Agreement and to initial Appendices A and B. The acceptance date for the new member will be the date their signed Letter Agreement and initialed appendices are received by FPRP.

If a physician leaves an established Blended Capitation Group of more than three physicians, the remaining three or more members will be asked to sign a declaration reflecting the change in group membership.

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. If and when a new member is recruited, the above procedure for adding a member to a Group is to be followed.

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.

11. 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.

Upon being onboarded to the billing system 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.

12. 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 fiscal (April 1 – March 31) 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**	**$ 215,097**
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	$ 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.

Income floors are not recalculated during the income floor period.

13. 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. Given MCP Billing rules, physicians will be *assessed for top-up eligibility** 90 days after the first six-month period following acceptance, then every 6 months thereafter.

*The determination of eligibility is a manual process and is subject to the availability of information from the MCP System, which depends upon cheque run dates which may not exactly coincide with your acceptance date. As such, it will be several weeks after the 90-day window has closed before top-up payments can be issued. The department has assigned a resource and is committed to ensure these payments are as timely as possible.

14. Grants and Stipend

Grants and stipends will be authorized for payment once all physicians within a BCG submit their signed letter agreements and appendices.

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

1. A $11, 250 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. The $10,000 Start-Up Grant is not available to physicians joining an established Group. An established group is defined as a Blended Capitation Group that has been billing under BCM for 18 months or longer.

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. Grants and stipends will be pro-rated in the event of a Physician's departure from the Model, as follows:

- One-Time Start-Up Grant ($10,000) – pro-rated
- Annual Quality of Care Stipend ($7,500) – pro-rated
- Transition Incentive ($11,250) – not pro-rated
- EMR Transition Grant ($30,000) – not pro-rated

Please see the Discontinuance Policy (Section 20), for details concerning the calculation and repayment of pro-rated grant and stipend funds.

15. 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.

For the Procedures Bonus, a "calendar year" is every twelve-month period starting with the acceptance date. For physicians who join an established BCG, who have a different acceptance date from the original group, the bonus will be pro-rated in the first year according to the number of days the physicians are in the model. For example, if the group's original acceptance date is April 1, 2024, and a physician joins the group on October 15, 2024, then the new physician would be eligible to receive a Procedures bonus on April 1, 2025, in the amount of:

$2,500/365 = $6.85 per day
Apr 1 to Oct 15 = 197 days
197 days x $6.85 = **$1,349.32**

16. Annual Quality of Care Stipend

Each physician, upon being accepted into the Program, will be entitled to receive 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. This stipend will be subject to FPRP guidelines. The FPRP will draw this funding from the redeployed FPRP Fee Code budget.

As per Schedule R, Section 3.14, to receive the annual $7,500 quality of care stipend, each physician accepted into the Blended Capitation Program must participate in activities to advance quality in practice.

The expectation is that physicians complete the equivalent of two qualifying activities (see Appendix A) over the course of a year to retain eligibility for the annual quality of care stipend. Suggested qualifying activities will be adjusted as new learning opportunities are developed to support family physician success with implementing the Blended Capitation Model, optimizing practice, and enhancing the quality of team-based primary care. Once a year the Blended Capitation Program staff will review the activities each physician has participated in. For participation in activities within any arm of the Family Practice Renewal Program, physicians will not be required to self-report. For participation in activities occurring outside the Family Practice Renewal Program, if those activities are needed to meet the two qualifying activity minimum, physicians will receive an email from program staff to confirm the activities participated in.

In the event of a Physician's departure from the Model, all grants and stipends received that year will be pro-rated, and overpaid funds will need to be returned.

The annual date for each physician is the date of acceptance into the Blended Capitation Program.

17. 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. Physicians should immediately work with eDOCS to begin the transition to the Provincial EMR.

18. 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.

19. 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. Upon termination, physicians will be contacted by FPRP with instructions concerning the return of any owing amounts for pro-rated grants and stipends.

Please see Sections 14 (Grants and Stipend) and 20 (Discontinuance) for details concerning the calculation and repayment of pro-rated grant and stipend funds.

20. Discontinuance

Participation in the Blended Capitation Model (BCM) is voluntary, and physicians may discontinue their enrolment by submitting a Blended Capitation Withdrawal Form at least 30 days before their desired end date (add link to form). Upon discontinuance from BCM, the physician shall notify attached patients that the physician will no longer be providing services under the Model.

Once a physician withdraws from BCM their patients will be de-rostered from the BCM billing system and the physician will return to billing 100% FFS. If they wish to rejoin the BCM they will need to re-apply by submitting a new Expression of Interest Form.

As per Section 9 of the Family Practice Renewal Committee's (FPRC) Policy on the BCM, if a physician's departure reduces their Blended Capitation Group (BCG) to fewer than three physicians, the BCG is expected to make a diligent effort to find a new physician to join the group as quickly as possible. FPRP will monitor the group's efforts every 12 months and will assist the BCG to identify and connect with other potential group members.

Once a Blended Capitation Withdrawal Form is received by the Family Practice Renewal Program (FPRP), the withdrawing physician will be contacted within 30 days with instructions concerning the return of any owing amounts for pro-rated grants and stipends.

- One-Time Start-Up Grant ($10,000) – pro-rated
- Annual Quality of Care Stipend ($7,500) – pro-rated
- Transition Incentive ($11,250) – not pro-rated
- EMR Transition Grant ($30,000) – not pro-rated

Returning Overpaid One-Time Start-Up Grant and Annual Quality of Care Stipend

The One-Time Start-Up Grant ($10,000) and Annual Quality of Care Stipend ($7,500) are based on one-year participation in the BCM, starting with the acceptance date (i.e., the date upon which the physician's signed Letter Agreement and initialed Appendices A and B are received by FPRP), and will be pro-rated in the event of a physician's departure from the Model. Overpaid funds will be recovered from the physician.

Overpayment recoveries will be coordinated by the FPRP and the departing physician will be invoiced for any overpayment with full payment due in 30 days.

The formula for calculating the amount of funds to return is as follows:
(Full fund amount / 365) x days enrolled in BCM = amount physician retains
Full fund amount – amount physician retains = amount physician returns

Example:
Physician enrolled for 90 days and decides to withdraw and return overpaid portion of $10,000 One-Time Start-Up Grant.
($10,000/365 days) x 90 days = $2,465.75
$10,000 - $2,465.75 = $7,534.25

Transition Incentive

The Transition Incentive ($11,250) is not pro-rated. Providing a physician has made a full transition to the BCM, no funds will be recovered. However, if a physician withdraws from the Model and later wishes to rejoin, a second Transition Incentive will not be paid.

EMR Transition Grant

The EMR Transition Grant ($30,000) is not pro-rated. Providing a practice has fully transitioned to the Provincial EMR, or is committed to completing the transition process, no funds will be recovered. However, if a practice leaves the Model and later wishes to rejoin, a second EMR Transition Grant will not be available.

Full transition to the Blended Capitation Model

Full transition to the BCM represents 18 months in the model (starting with the physician's date of acceptance).

21. ***Appendix A – Qualifying Activities for Annual Quality of Care Stipend***

** Physicians must complete the equivalent of two qualifying activities over the course of a year to retain eligibility for the annual quality of care stipend.*

Activity	Qualifying Activity Equivalent
Completion of a MyQ self-directed online module.	Equal to two qualifying activities.
Participation in MyQ Blended Capitation Physician Network calls.	Attendance at one network call equals one qualifying activity.
Meetings with the Practice Facilitator, Blended Capitation and MyQ programs on Blended Capitation onboarding or Quality Improvement (QI) projects.	One meeting equals one qualifying activity.
Participation in FPRP's Practice Improvement Program Continuing Professional Development Programs.	Completion of a program counts as two qualifying activities.
Engagement in additional activities undertaken to improve the quality of care for patients, examples include but are not limited to: • Panel review and panel management activities. • Rostering of patients into blended capitation. • Meeting with an EMR Practice Advisor to implement the MyQ dashboard or other reports/dashboards for the purpose of quality improvement. • Participation in FPRP, Practice Improvement Program, Family Practice Network or Collaborative Services Committee initiatives aimed at improving care for patients. • Independent QI projects as demonstrated by submitted Continuing Professional Development certificates or credits or improvement storyboards providing a visual summary of a completed QI initiative.	One activity equals two qualifying activities.

For further information on the Family Practice Renewal Program please visit https://familypracticerenewalnl.ca/