Impact of Government Unilateral Action on Family Medicine and Primary Care Physicians

PAYMENT DISCOUNT

The Ministry of Health and Long-Term Care (the ministry) unilateral action plan includes a 2.65% across-the-board discount to all physician payments. This discount is expected to be applied to fee-for-service payments effective February 1, 2015 and to primary care models, primary care specialized models, AFP/APP agreements and physician programs effective May 1, 2015. This discount is in addition to the current 0.5% payment discount. Further, the Ministry invites the OMA to participate in a working group to develop implementation of a reverse relativity savings process – either by specialty specific discounts, or savings initiatives within each specialty that could replace part of this across-the-board discount.

PAYMENT DISCOUNT ON PRIMARY CARE MODELS

For primary care models, including specialized models, the 2.65% discount is expected to be applied to the same components of the agreements as the 0.5% discount negotiated as part of the 2012 PSA. The methodology for applying the discount is also expected to be similar to that of the 0.5% discount. The ministry has indicated that it would terminate agreements with physician groups who do not agree to the adjusted funding levels.

GP SPECIALIZED MODELS

Agreements impacted include, but are not limited to: Rural and Northern Physician Group Agreement (RNPGA 1 and 2); Weeneebayko Health Authority (WHA); GP Focus – Palliative APP; GP Focus – HIV APP; GP Focus – Care for the Elderly; Toronto Palliative Care; Algonquin FHT; St. Joseph's Health Centre; Community Health Centres; Aboriginal Health Access Centres (AHAC); Blended Salary Model (cFHT); Sherbourne; Shelter Health Network; Inner City Health (ICHA); Sioux Lookout; and Group Health Centre (GHC).

If you are uncertain on whether your contract is impacted please contact negotiations@oma.org.

RECONCILIATION

Further, the ministry has established a fixed amount of spending on the whole of physician services. If spending is higher than planned, the money would be recovered from physicians at the end of the second and third year. We do not have information as to how this may be applied to primary care models, or GP Specialized models.

CONTRACT AMENDMENTS

Contract amendments are required to increase the payment discount by an additional 2.65% for each contract – primary care, APPs, certain programs and HOCC contracts – this would come into effect May 1, 2015.

Further information on APPs/AFAs and Program Changes can be found on the OMA website.

Changes would need to be made to primary care contracts for the removal of the enrolment fees, CME payments, and restricting income stabilization

The government has indicated that under unilateral action, it will propose amendments to primary care contracts or terminate a contract if a party does not agree.

SPECIFIC INITIATIVES

In addition to the proposed discounts, government also plans to implement a number of targeted initiatives totalling $259M. The majority of these initiatives specifically impact family physicians, with a further impact on new family medicine graduates.

IMPACT ON ALL FAMILY PHYSICIANS

Details of each of the government initiatives impacting family physicians in addition to the payment discount are presented below. These are estimated to have a -3.4% impact on average, in addition to the 2.65% payment discount. This varies amongst physicians, particularly for new entrants (see New Graduate Impact section at end).

1. ***Elimination of Enrolment Premiums ($48M, 2015/2016)***

Effective May 1, 2015, eliminate the following enrolment Q codes: Q200, Q201, Q202, Q013, Q033, Q054, Q055, Q056, Q057 and complex vulnerable top ups on capitation and fee for service. Ministry also plans to eliminate the Health Care Connect (HCC) program.

It is estimated that first year family physicians eligible to bill these codes will lose on average $30,000 per year in enrolment premiums and established family physicians will lose $5,000.

The three codes that would be retained are for unattached acute enrolment (Q023), FOBT positive enrolment (Q043), and HCC complex vulnerable enrolment (Q053) codes. The Health Care Connect (HCC) program and associated payments will be discontinued.

2. ***Managed Entry ($13M, 2015/2016)***

Government will reduce the net new number of physicians joining existing or starting new FHN or FHO groups from 40 to 20/month, furthermore physicians will only be allowed to join or start FHN or FHO groups in areas of “high need”.

The alternative for new physicians who do not relocate to these areas will be to join a FHG, a Comprehensive Care Model (CCM, solo comprehensive care), or bill fee for service. The only way that new graduates or family physicians wishing to convert can participate in a comprehensive care capitation family practice model is if they become a locum for an existing group, or replace a departing physician.

Based on Ministry estimates of current average payment by model type, average payment in a FHO is $70,000 more than the CCM and $30,000 more than the FHG. Therefore the loss ranges from $30,000 to $70,000.

Currently, the number of net new physicians joining FHN and FHO is limited to 40 physicians per month but only 20 are prioritized (for new graduates or by location); the remaining 20 are on a first come, first served basis and unused spaces are carry forward.

3. ***Income Stabilization – restriction to “underserviced” areas only ($9M, 2015/2016)***

The Income Stabilization (IS) program (FHN and FHO models) would only be offered in areas deemed "underserviced" by the Ministry.

This has a disproportionate impact on new family physician graduates. IS provides stable monthly payments to Physicians joining the FHN/FHO in the first year of their practice. Base Annual remuneration under the program is $201,330 (urban) and $220,814 (rural) before discounts.

According to the Ministry, payment changes would be implemented effective May 1, 2015 after notification in January 2015. Contracts would be terminated if a party does not agree.

4. Elimination of the CME program ($12M in 2014/2015, $24M in 2015/2016)

All CME payments would be discontinued including Q code premiums paid to primary care physicians, Rurality Index for Ontario (RIO) based CME, and the Northern Physician Retention Initiative (NPRI) CME.

Government will eliminate the RIO-based CME program effective January 2015 which means there will be no reimbursement of 2014 CME expenses. The existing program defines funding levels from $1,250 to $7,500 per year based on degree of rurality (RIO scores of 0 are ineligible).

NPRI-eligible physicians with a RIO score of 40 or less are entitled to up to $2,500 in reimbursement for CME expenses. The NPRI CME is a top up to the funding received through the CME Program. Funding in respect of fiscal 2014/2015 would be discontinued.

Effective May 1, 2015 CME Q-codes (Q555, Q556 and Q557), paid to applicable primary care models based on time spent completing CME, will also be eliminated. These are paid at a rate of $100/hour for up to 24 hours ($2,400) per fiscal year.

5. Acuity Modifier – delay ($40M in 2014/2015 & $40M in 2015/2016)

The acuity modifier is funding of $40 million per year paid to physicians in patient enrolment models based on the acuity of patients enrolled. Government will not pay the 'interim' Acuity Modifier for two years, and until the final acuity modifier is implemented. The first interim acuity modifier payment was made in January 2014, average payments ranged from $4,000 to $6,000, and vary based on the enrolment of higher acuity patients.

6. A888 - ~~Walk-In Clinics~~ ($14M)

The A888 fee is being reduced to the value of an A007, where the A888, emergency department equivalent partial assessment, is an assessment rendered on a Saturday, Sunday or Holiday for the purpose of dealing with an urgent medical problem.

The government's stated purpose is to reduce payments to "walk-in clinics". The reduction to A888 (from $35.40 to $33.70) applies broadly to family medicine. The A888 is outside of the FHO and FHN 'basket' of services. The reduction also impacts the FHG 10% premium on A888 and the 30% Q012 and Q016 premiums. Furthermore, there is no clear definition of what a "walk-in clinic" is.

7. HOCC One Time (Per Diem) Payment (24M in 2014/2015; 12M in 2015/2016)

HOCC Per Diem One Time Payment to provide additional compensation for HOCC groups with less than five physicians providing additional coverage above their minimum on call coverage requirements will not be paid. The regular HOCC program is not impacted.

8. HOCC Freeze ($3M, 2015/2016)

Effective April 1, 2015, HOCC funding will be frozen at current levels. This means that new groups (including those waiting approval) will not be approved nor will additions to existing HOCC groups be permitted.

9. Chronic Disease Assessment Premiums E078 ($24M, 2015/2016)

This proposal does not impact family practice. Internal Medicine, Cardiology, Gastroenterology and Nephrology would no longer be eligible for Chronic Disease Assessment Premiums

SPECIFIC IMPACT ON NEW GRADUATE FAMILY PHYSICIANS

Government proposals on (i) enrolment premiums, (ii) managed entry (new FHO physicians limited to 20/month) and (iii) income stabilization have specific, negative impacts on new family medicine graduates.

Unless new graduates relocate to a priority area, *and* the limit hasn't been reached, they cannot join a FHO/FHN (unless they replace a departing physician).

New family medicine graduates are not eligible for income stabilization unless located in a priority area - stable monthly payments provided in the first year of practice in FHO/FHN models to enable them to build their practice.

New graduates have a financial loss ranging from $30K to $100K resulting from government changes: $30K in enrolment premiums plus, if locating in a non-priority area, either $70K based on joining a CCM or $30K for joining a FHG instead of joining a FHO.

Even if the physician locates/relocates to join a FHO in a 'high need' area they still lose $30K due to elimination of enrolment codes.