MINISTRY OF HEALTH AND LONG-TERM CARE
Primary Health Care Team

FACT SHEET

To: **Family Health Teams**

Title: **Family Health Team Blended Salary Model for Physicians**

Date: **December 4, 2006**

Eligible Family Health Teams:

☑ Community-Sponsored Family Health Teams
☑ Mixed-Governance Family Health Teams

Introduction

The *Family Health Team Guide to Physician Compensation* [the Guide] describes three basic compensation options available to family physicians in Family Health Teams: Blended Capitation, Blended Complement, and the Blended Salary Model.

As noted in the Guide, the salary range, incentives and premiums have been developed through discussions held between the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care in the Family Health Team Working Group. The following provides a detailed overview of the *Family Health Team Blended Salary Model for Physicians*. This model was approved by the OMA board on June 14, 2006, and will be made available to physicians who are employees of a community-sponsored or mixed-governance Family Health Team. The Ministry will hold the Family Health Team accountable to provide compensation as set out in its agreement and submit appropriate reports to the Ministry.

Family Health Team Blended Salary Model

This model has been designed to ensure that Family Health Team physicians are compensated fairly and appropriately for providing a comprehensive set of services to their enrolled patients. The model accounts for patient and population needs, and ensures consistency and equity with other compensation models available to Family Health Team physicians.

Guiding Principles

The following policy principles were used to guide the development of the Family Health Team blended salary compensation framework:

1. *Appropriateness:* The compensation framework should be shaped by the predicted characteristics and needs of the patient population (e.g., smaller urban or rural communities) in order to attract the target physician group that may be interested in a blended salary option.

2. *Consistency:* The base salary and payment elements (e.g., premiums and incentives) should be consistent with those included in the other compensation frameworks available to Family Health Team physicians.

3. *Relativity:* The salary should be comparable to the income earned in the other available compensation frameworks and should be relative to the basket of services and number/needs of patients served.

4. *Comprehensiveness:* The payment elements should reward physicians for providing, overseeing or coordinating a comprehensive range of services to their enrolled patients and encourage the provision of priority services through the use of targeted incentive payments.

5. *Accountability:* The compensation framework requires encounter reporting to ensure that the level of compensation is reflective of the range of services provided to enrolled patients and to facilitate future planning and evaluation activities.

MODEL DETAILS

The Family Health Team Blended Salary Model has the following components:

1. Base Salary Linked to Enrolment
2. Incentives, Premiums and Special Payments
3. After Hours Services
4. Telephone Health Advisory Service
5. Access Bonus
6. Operational Overhead
7. Benefits
8. Locum Coverage
9. Shadow Billing Premium and Fee-For-Service Billings
10. Information Technology

1. Base Salary Linked to Enrolment

Salary levels are linked to an individual physician's target roster size. The salary levels available as of April 1, 2006, are as follows:

Salary Level	Target Roster Size	Salary
Level 1	1,300	$130,793.71
Level 2	1,475	$148,296.50
Level 3	1,650	$165,799.30

Salary level determination will be based on a physician's actual roster in comparison to target roster size as of March 31st of the previous fiscal year. Blended Salary Model physicians are expected at the outset to attain one of the three target roster sizes (1,300, 1,475, or 1,650) and then to sustain enrolment with as little variance as manageable around that target. A physician's salary will be at level 1 upon enrolling 1,300 patients, and will increase from level 1 to level 2 upon enrolling 1,475 patients, and from level 2 to level 3 upon enrolling 1,650 patients. The maximum salary paid for level 3 is $165,799.30.

Acting through their Family Health Team, a physician may request a salary adjustment due to changes in the actual size of their roster. Similarly, a review may be undertaken at the request of the Ministry. Subsequent to each review, the Ministry will notify each Family Health Team of any salary level adjustments.

If a physician's actual roster size decreases by greater than 10% of their target roster size, (i.e., from 1,650 to fewer than 1,485 at level 3 and from 1,475 to fewer than 1,327 at level 2), then the physician's salary may be adjusted to the next lower salary level for the next fiscal year. In the case where a physician's actual roster size decreases by greater than 10% of the first target roster size (i.e., from 1,300 to fewer than 1,170), the salary amount will be pro-rated on a per-patient basis proportional to salary level 1. Physicians are required to meet the established target roster size for their salary level within the upcoming fiscal year to maintain their current payments.

Once a physician rosters a minimum of 1,300 patients, their employment status would be considered full-time or 1.0 FTE. Full-time physicians are expected to provide 40 hours of service per week to the Family Health Team and are entitled to 4 weeks paid vacation.

A physician who rosters fewer than 1,300 patients would be considered part-time, and the salary would be pro-rated on a per-patient basis proportional to salary level 1. Vacation entitlement would also be pro-rated accordingly.

2. Incentives, Premiums and Special Payments

Similar to Harmonized Models, Blended Salary Model physicians will be eligible to claim incentives, premiums and special payments for which they meet the stated requirements, as per the 2004 Memorandum of Agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association. Please refer to Appendix A for a descriptive, comprehensive list of eligible premiums and incentives, noting that prior *Fact Sheets* containing additional details have been disseminated on these matters and are available to OMA members only through the Ontario Medical Association website under the Primary Care Models section at www.oma.org/PC/index.asp or to Family Health Teams through your Family Health Team Coordinator.

Blended Salary Model physicians should note that the Group Management and Leadership Payment (GMLP), the Seniors Care Premium and the Newborn Care Episodic Fee are included in their funding as follows: Funding for GMLP services are provided through the operational overhead component of the Blended Salary Model and the Blended Salary Model base payment has been adjusted to include the Seniors Care Premium and the Newborn Care Episodic Fee.

Please note, for Blended Salary Model physicians, all premiums, incentives and special payments will be paid directly to the Family Health Team and distributed according to its governance arrangement.

3. After Hours Services

After Hours Service availability is based on similar conditions as the Family Health Group Letter of Agreement.

Each Blended Salary Model physician is required to be available for one 3 hour session from Monday to Thursday night (from 5:00 p.m. to 8:00 p.m.) or for a 3 hour session on the weekend. The Family Health Team may elect to commence After Hours Services on weeknights at a time later than 5 p.m., but no later than 7 p.m., and shall provide at least 3 full hours of After Hours Services on such nights.

Services delivered on Sundays can be counted towards achievement of the requirement of weekend after hours coverage. If both Saturday and Sunday services are provided, two 3 hour blocks of weekday after hours time would be considered to have been met.

If the Family Health Team consists of only one physician, at least one physician shall provide one block of after hours weekday, or weekend services, and if there are 2 physicians, at least 2 blocks of after hours are required to be covered.

For larger Family Health Teams comprising 5 or more physicians, a physician is required to be available for one 3 hour session on the weekend. In addition, the staffing of additional physicians may be necessary if the Family Health Team determines that this is warranted by volume and the needs of its patient population.

If more than 50% of physicians within the Family Health Team provide regular, ongoing emergency room coverage, anaesthesia services, or obstetrical deliveries, they may be eligible to receive an exemption from the Ministry for evening and weekend coverage upon written request.

Physicians are eligible to claim the After Hours Premium, which includes a 20% premium of the full value of fee schedule codes A001, A003, A004, A007, A008, A888, K005, K013, and K 017 for valid claims for After Hours Services provided to enrolled patients during a scheduled After Hours session.

4. <u>Telephone Health Advisory Service</u>

Telephone Health Advisory Service (THAS) includes advice and referral information, triage to self-care, and access, where appropriate, to an on-call physician who is permitted access to the medical records of the enrolled patients and, if essential, to a public hospital emergency department. THAS service includes appropriate feedback to the rostered physician when an enrolled patient contacts the THAS provider.

Family Health Teams are required to provide THAS services to enrolled patients Monday to Thursday from 5 p.m. to 9 a.m., and Friday from 5:00 p.m. to Monday at 9:00 a.m., including recognized holidays.

Physicians are eligible to receive a payment for being on call to the THAS. This dollar amount is at the discretion of the Family Health Team governance arrangement and is based on the number of physicians required to support the THAS service obligations for the Family Health Team.

The Ministry is exploring possible changes to THAS on-call service obligations in response to concerns of Family Health Teams having a relatively small physician complement.

5. <u>Access Bonus</u>

Blended Salary Model physicians have an opportunity to earn an access bonus equal to a maximum value of 8.69% of their salary. Payment is based on a physician's success in providing core services to their enrolled patients and minimizing the need for enrolled patients to seek these services from other primary care physicians. The access bonus will be calculated and paid semi-annually based upon the complete claims data available to the Ministry for the semi-annual period.

The access bonus is calculated by subtracting from the possible maximum 8.69% payment the total value of all claims paid by the Ministry to other physicians for insured services described as Blended Salary Model core services provided to the blended salary physician's enrolled patients. The resulting

amount is the access bonus payable to the blended salary physician for that period. Where the calculated amount is either zero or negative, the blended salary physician receives no access bonus payment for the period.

Please note, claims from physician specialists, identified general practitioner specialists, including those who provide psychotherapy, and affiliated Family Health Team physicians, are exempted from this calculation. Other excluded services include oculovisual assessments, obstetrical deliveries and emergency room claims plus their associated codes or premiums.

6. Operational Overhead

The overhead cost for each Blended Salary Model physician is integrated into the overhead and operating expenses of their Family Health Team.

For the purposes of specifying operational overhead, Family Health Teams should include in their Business and Operating Plan items such as rent, insurance[1], travel and supplies for each Blended Salary Model physician on a line-by-line basis. Operational overhead is separate from, and does not form part of, human resources and/or transitional funding.

Groups can be comfortable telling prospective salaried physicians that the Family Health Team is receiving a reasonable payment to cover the average costs of a practicing physician, and no additional payments will be requested from the physician for overhead.

7. Benefits

Benefits are calculated at 20% of the physician salary. This component is paid directly to the Family Health Team, which has the responsibility in conjunction with the physician on whose behalf the payment is made to determine the benefit compensation package.

Benefit payments to the Family Health Team will be pro-rated for part-time physicians.

8. Locum Coverage

As per the CHC model, locum coverage will be provided and calculated at 5% of a physician's salary for Family Health Teams that do not qualify for funding under the OMA Locum Program for Rural Physicians.

Each Family Health Team will have the ability to hire contracted physicians to provide locum coverage for blended salary model physicians.

9. Shadow Billing Premium and Fee-For-Service Billings

Blended Salary Model physicians are eligible to receive a shadow billing premium representing 5% of the value of valid claims in accordance with the *Health Insurance Act* when core services included in the Blended Salary Model are provided to enrolled patients.

[1] Physicians are eligible for reimbursement for physician malpractice insurance as part of the Ministry's agreement with the Canadian Medical Protective Association through the Malpractice Reimbursement Program. In addition to this provision, as employees, Blended Salary Model physicians are eligible for reimbursement through the physician overhead component of that portion of their malpractice insurance premiums not covered by the Malpractice Reimbursement Program. Such reimbursements for Blended Salary Model physicians will be based on actual, rather than projected, malpractice insurance premium amounts.

Core services provided by Blended Salary Model physicians to non-enrolled patients within the Family Health Team are billed fee-for-service and paid up to a maximum of $15,000 per FTE Blended Salary Model physician in the Team.

Conditional on the physician fulfilling their required hours of service to the Family Health Team, there will be no limit on fee-for-service billings for patient services provided “outside” the Family Health Team. Outside services refers to services provided to non-enrolled patients in locations other than Family Health Team premises, or utilizing any of the support staff or services of the Family Health Team.

Blended Salary Model physicians are eligible to bill fee-for-service for codes outside the Blended Salary Model basket, including codes for emergency room unscheduled visits and obstetrical deliveries at 100% of the fee value along with their associated premiums (the excluded codes are identified in the table on page seven of this document).

For physicians who are receiving Comprehensive Care Capitation payments for their previously enrolled patients, prior rates will be honoured.

10. Information Technology

Blended Salary Model physicians are eligible to receive funding and support for information technology through the Physician IT Program provided by OntarioMD.

Information Technology funding will be prorated for part-time physicians.

The Physician IT program is a comprehensive program that assists physicians in the acquisition, implementation and adoption of information technology. Transition Support Specialists are available to provide direct assistance to physicians, staff and other group colleagues participating in Family Health Teams. Through self-help tools like checklists, workshops, and planning guides, the Transition Support Program will help providers optimize their use of information technology.

Several Clinical Management System (CMS) products have been approved by the Physician IT Program that fully integrate electronic medical records, billing and scheduling requirements. Information on approved CMS products is available at www.ontariomd.ca/cms/.

OPERATIONALIZATION OF THE BLENDED SALARY MODEL

Roster Development

If a physician is not receiving income stabilization payments, the physician may choose to roster patients under the CCM or FHG model and receive payments under this model for a 12 month period while building their patient roster. Once the target roster size is reached or the 12 month period ends, whichever occurs first, the physician will progress to the Blended Salary Model.

Further details of income stabilization and roster development will follow.

Please see attached Questions and Answers (Appendix B) that have been prepared to assist in considering this compensation model.

The following table summarizes the potential value of the Blended Salary Model compensation package for family physicians:

Blended Salary Model Component	Value
Base Salary effective April 1, 2006	Level 1 - $130,793.71 Level 2 - $148,296.50 Level 3 - $165,799.30
Incentives, Premiums and Bonuses	Please refer to Appendix A for complete list.
After Hours Premium	Blended Salary Model physicians can earn 20% of the full value of fee schedule codes A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A and K017A for valid claims for After Hours Services provided to enrolled patients.
Telephone Health Advisory Service	The average value for physicians providing THAS is $400 per month / physician up to a maximum of $2,000 per Family Health Team based upon a maximum group size of five physicians, however payment will ultimately depend on the governance arrangement and the number of physicians participating in the provision of the service.
Access Bonus	Equal to 8.69% of the physician's blended salary level.
Operational Overhead	Each Family Health Team will cover the business related operational overhead expenses for each Blended Salary Model physician.
Benefits	Equal to 20% of the physician's salary level. Estimated value is between $26,158.74 and $33,159.86 for physicians with 1,300 to 1,675 enrolled patients, respectively.
Locum Coverage	Equal to 5% of the physician salary level for Family Health Teams that do not qualify under the OMA Locum Program.
Shadow Billing Premium	Payment equal to 5% of valid claims in accordance with the *Health Insurance Act* for core services provided to enrolled patients.
Information Technology	Funding and support through OntarioMD based on physician FTE status.
Fee-For-Service Billings	Eligible to bill fee-for-service for core services provided to non-enrolled patients within the Family Health Team to an annual maximum of $15,000 per FTE physician. In addition, physicians can bill fee-for-service for all non-core services rendered to both enrolled and non-enrolled patients including codes specific to the provision of emergency room unscheduled visits and obstetrical deliveries. Applicable codes include K990, K991, K992, K993, K994, K995, K996, K997, H055, H065, H101, H102, H103, H104, H105, H112, H113, H121, H122, H123, H124, H131, H132, H133, H134, H151, H152, H153, H154, H400, H401, H402, H403, H404, H405, H406, H407, H408 and P006, P020, E502, P018, P041, P042, E500, P038, P009, P010, P022, P023, P028, P029, P030, P036, P039, Z774, C989, E409, E410, E411, E414, Z775 and Z776. (Note: fee codes billed in association with the above 'K' codes are also considered excluded.)

Next Steps

If you are a family physician either setting up or contemplating practice in an eligible Family Health Team, you are encouraged to **contact your Ministry Site Team at 1-866-766-0266** for more information.

APPENDIX A

ELIGIBLE INCENTIVES, PREMIUMS AND SPECIAL PAYMENTS
Available as of April 1, 2006

Each physician in the Blended Salary Model is eligible to bill fee-for-service for core services provided to non-enrolled patients within the Family Health Team to an annual maximum of $15,000.

Additionally, Blended Salary Model physicians are entitled to other payments as per Schedule "E" of the Community-Sponsored Family Health Team Contract. The excerpts of the contract, below, exclude associated appendices and details of the conditions for claiming payment; please consult the full contract text for these details.

3.4 Premiums and Bonuses

3.4.1 Comprehensive Care Capitation Payments

A physician shall be entitled to the following average monthly comprehensive care capitation rates for each enrolled patient:

a. An average monthly capitation rate of $1.42 per Enrolled Patient;

b. Twelve (12) months thereafter the average monthly capitation rate will increase to $1.80 per Enrolled Patient; and

c. On January 1, 2008, the average monthly capitation rate in paragraph a will increase to $1.50 and the average monthly capitation rate in paragraph b will increase to $2.15.

The actual age and sex adjusted capitation rates may be calculated by multiplying the rates listed in Appendix 2 of this Schedule [E] by the dollar amount quoted above.

3.4.2 Shadow Billing Premiums

Salaried Physicians will receive a 5% shadow billing premium for encounter reporting (to be submitted to the CS by the physician and included in the Recipient reports to the Ministry).

3.4.3 Minimizing Outside Use Premium

A physician is entitled to be paid an amount based on his/her success in providing to their enrolled patients all the Services required by the Enrolled Patients. This amount will be calculated and paid semi-annually for each Enrolled Patient based upon the complete claims data available to the Ministry for the semi-annual period. The amount of each semi-annual payment shall be 5% of that physician's Base Salary amount, minus the total value of all claims paid by the Ministry to non-CS physicians (other than specialists), for insured services rendered to Enrolled Patients which are funded pursuant to this Agreement during the semi-annual period. This outside use formula shall not apply to:

(i) Oculo-visual assessments (A110, A112); and

(ii) GP Psychotherapy, as defined for the purposes of the Agreement as a Physician whose annual billing amounts for the following codes has totalled 50% or greater of their total annual fee-for-service billings in the preceding twelve (12) months: K004, K006, K007, K010, K011, K012, K024, and K025.

3.5 Service Enhancement Codes

Each physician may submit claims for the following Service Enhancement Codes pursuant to the terms set out below. All references to an Enrolled Patient are intended to include an Enrolled Patient's parent or guardian where appropriate.

(a) Preventive Care Management Service Enhancement Codes

A Service Enhancement Fee of $6.86 is payable to a physician for each Enrolled Patient he or she contacts for the purpose of scheduling an appointment for one of the following Preventive Care Management tests / procedures:

(i) Pap smear: Q001A

The Service Enhancement Fee may be claimed biennially for each Enrolled Patient, between 35 and 70 years of age and at risk of cervical cancer, who is contacted for the purpose of scheduling a Pap smear and who is not excluded from the target population as set out in subsection 3.5(c)(ii) of this Schedule [E].

(ii) Mammogram: Q002A

The Service Enhancement Fee may be claimed biennially for each female Enrolled Patient, between 50 and 70 years of age and at risk of breast cancer, who is contacted for the purpose of scheduling a mammogram and who is not excluded from the target population as set out in subsection 3.5(c)(ii) of this Schedule [E].

(iii) Influenza Vaccine for Enrolled Patients over 65: Q003A

The Service Enhancement Fee may be claimed annually for each Enrolled Patient, over the age of 65, who is contacted for the purpose of scheduling an influenza vaccination.

(iv) Immunizations for Enrolled Members under Two Years: Q004A

The Service Enhancement Fee may be claimed once for each Enrolled Patient, between 18 months and 2 years of age, whose parent or guardian is contacted for the purpose of scheduling an appointment for Ministry supplied immunizations pursuant to the guidelines set by the National Advisory Committee on Immunization.

(v) Colorectal Screening: Q005A

The Service Enhancement Fee may be claimed biennially for each Enrolled Patient, between 50 and 74 years of age (inclusive), at risk of colorectal cancer and who is not excluded from the target population (as set in section 3.5 (c)(v) of this Appendix), who is contacted for the purpose of scheduling a fecal occult blood test.

(c) Cumulative Preventive Care Management Service Enhancement Codes

A physician may claim the following Service Enhancement Codes for the high cumulative level of preventive care to his or her roster of patients. A physician may make one claim per year for each of the following five headings per year:

(i) Influenza Vaccine for Enrolled Patients over 65

This Service Enhancement Fee calculated annually based on the percentage of Enrolled Patients rostered over the age of 65 and who have received the influenza vaccine appropriate for that influenza season and before December 31st of that fiscal year.

Percentage of Enrolled Patients	*Fee Payable*	*Service Enhancement Code*
60%	*$220*	*Q100*
65%	*$440*	*Q101*
70%	*$770*	*Q102*
75%	*$1100*	*Q103*
80%	*$2200*	*Q104*

(ii) Pap smear

This Service Enhancement Fee is calculated annually based on the percentage of female enrolled patients rostered between 35 and 70 years of age, are not excluded from the target population (as set out below) and who have had a Pap smear in the previous 24 months as of March 31, 2004, or in the previous 30 months as of March 31, 2005, and every subsequent March 31 thereafter.

Percentage of Enrolled Patients	*Fee Payable*	*Service Enhancement Code*
60%	*$220*	*Q105*
65%	*$440*	*Q106*
70%	*$660*	*Q107*
75%	*$1320*	*Q108*
80%	*$2200*	*Q109*

The following Enrolled Patients are excluded from the target population for pap smears:
(i) Female Enrolled Patients who have had a hysterectomy; and
(ii) Female Enrolled Patients who are being treated for cervical disease that precludes regular screening for pap testing.
The applicable exclusionary code for pap smears is Q140.

(iii) Mammogram

This Service Enhancement Fee is calculated annually based on the percentage of female Enrolled Patients between 50 and 70 years of age, are not excluded from the target population (as set out below) and who have had a mammogram in the previous 24 months as of March 31, 2004, or in the previous 30 months as of March 31, 2005, and every subsequent March 31 thereafter.

Percentage of Enrolled Patients	*Fee Payable*	*Service Enhancement Code*
55%	*$220*	*Q110*
60%	*$440*	*Q111*
65%	*$770*	*Q112*
70%	*$1320*	*Q113*
75%	*$2200*	*Q114*

The following Enrolled Patients are excluded from the target population for mammograms:

(i) Female Enrolled Patients who have had a mastectomy; and
(ii) Female Enrolled Patient who are being treated for clinical breast disease.

The applicable exclusionary code for mammograms is Q141.

(iv) Immunizations for Enrolled Patients under Two Years

This Service Enhancement Fee is calculated annually based on the percentage of enrolled patients who are between 18 months and two years of age who have received all of the Ministry supplied immunizations recommended by the National Advisory Committee on Immunization in the previous 24 months as of March 31, 2004 or in the previous 30 months as of March 31, 2005, and every subsequent March 31 thereafter. To claim this Service Enhancement Fee, the physician must retain detailed records, including the name of the vaccine, lot number, manufacturer, date of immunization, and route of administration.

Percentage of Enrolled Patients	*Fee Payable*	*Service Enhancement Code*
85%	*$440*	*Q115*
90%	*$1100*	*Q116*
95%	*$2200*	*Q117*

(v) Colorectal Screening

This Service Enhancement Fee is calculated annually on an individual FHN Physician basis based on the percentage of Enrolled Patients who are between 50 and 74 years of age (inclusive), are not excluded from the target population (as set out below) and who have had a fecal occult blood test in the previous 30 months as of April 1, 2006, and every subsequent March 31 thereafter.

Percentage of Enrolled Patients	*Fee Payable*	*Service Enhancement Code*
15%	*$220*	*Q118*
20%	*$440*	*Q119*
40%	*$1,100*	*Q120*
50%	*$2,200*	*Q121*

In order to be eligible for this Service Enhancement Fee, the Physician's evaluation will include a review of the Enrolled Patient's family history and fecal occult blood test, where appropriate. The current Cancer Care Ontario guidelines will apply for ambiguous or positive results. To claim this Service Enhancement Fee, the Physician must retain

detailed records documenting the provision of this service, his/her evaluation and the results of the same.

The following Enrolled Patients are excluded from the target population for colorectal screening:

(i) Enrolled Patients with known cancer being followed by a physician;
(ii) Enrolled Patients with known inflammatory bowel disease;
(iii) Enrolled Patients who have had colonoscopies within five (5) years;
(iv) Enrolled Patients with a history of malignant bowel disease; and
(v) Enrolled Patients with any disease requiring regular colonoscopies for surveillance purposes.

The applicable exclusionary code for colorectal screening is Q142.

(d) Targeted Medical Education Service Enhancement Codes *Q555*

A Service Enhancement Fee of $100.00 per hour is payable annually to a physician for each hour that he or she spends at a continuing medical education conference or seminar, subject to the following condition:

(i) The conference/seminar must have been approved by a joint committee of the OMA, the Ministry, Institute of Clinical Evaluative Sciences, and the Ontario College of Family Physicians;
(ii) A physician may claim a maximum of 24 hours per year; and
(iii) The physician must retain proof of attendance at the conference/seminar.

3.6 Special Payments

A physician is eligible to qualify for each of the special payments described below in any fiscal year. Special payments will not be paid for both obstetrical deliveries and prenatal care. The provision of any services listed in sections 3.6(d),(e), and (f) by a nurse practitioner will count towards the physician's fulfillment of the obligations to qualify for each of these Special Payments provided that the nurse practitioner submits valid claims for these services on behalf of the physician in accordance with the provisions of this Schedule.

(a) Special Payment For Obstetrical Deliveries

A physician shall receive an additional $3,200.00 after submitting valid claims for five (5) or more services from the list set out in Appendix 3 to five (5) or more patients in any fiscal year.

(b) Special Payment For Hospital Services

A physician shall receive an additional $5,000.00 after submitting valid claims for services totalling $2,000.00 in any fiscal year from the list of services set out in Appendix 4.

Effective the later of April 1, 2005, and the Commencement Date, the amount payable shall be increased from $5,000.00 to $7,500.00 for a physician who is located in either:

(i) an area with a score on the OMA Rurality Index of Ontario (“OMA RIO”) greater than 45 (the “Designated RIO Area”); or

(ii) one of the following five (5) Northern Urban Referral Centres: Sudbury, Timmins, North Bay, Sault Ste Marie or Thunder Bay, or such other northern community that may be agreed to in writing by the OMA and the Ministry.

In order to be eligible for the $7,500.00 payment, either the office in which the physician regularly provides Services (as registered with the Ministry) or the hospital in which he/she regularly provides hospital services will be located in the Designated RIO Area or the Northern Urban Referral Centre (as the case may be).

(c) Special Payment For Palliative Care

A physician shall receive an additional $2,000.00 after submitting valid claims for fee schedule code K023 for four (4) or more palliative care patients in any fiscal year.

(d) Special Payment For Office Procedures

A physician shall receive an additional $2,000.00 after submitting valid claims for services to enrolled patients totalling $1,200.00 or more in any fiscal year from the list of services set out in Appendix 5.

(e) Special Payment For Prenatal Care

A physician shall receive an additional $2,000.00 after submitting valid claims for fee schedule codes P003 and/or P004 for prenatal care during the first 28 weeks of gestation for five (5) or more enrolled patients in any fiscal year.

(f) Special Payment For Home Visits (Other Than Palliative Care)

A physician shall receive an additional $2,000.00 after submitting valid claims for fee schedule codes A901 and/or A902 for one hundred (100) or more home visits to Enrolled Patients in any fiscal year.

3.7 Premiums for Primary Health Care of Patients with Serious Mental Illness

A physician shall receive an additional $1,000 per fiscal year when, during that fiscal year, at least five patients with diagnoses of bipolar disorder or schizophrenia are rostered with the physician. Fee Schedule codes for services provided to these patients must be accompanied by tracking code Q021 for schizophrenia and tracking code Q020 for bipolar disorder, and the patient must be rostered in order for the premium to be paid.

A physician shall receive an additional $1,000 ($2,000 in total) for the Mental Health Care premium for at least an additional 5 patients (i.e., at least 10 patients in total) subject to the rules provided above.

Note: The Mental Health Premium will be paid to the physician by the claims payment system based on claims data.

3.8 After Hours Premium (Q012A)

The physician shall be paid a 20% premium on the full value of fee codes A001, A003, A004, A007, A008, A888, K005, K013, and K017 for valid claims for Evening and Weekend Hours Services provided to Enrolled Patients.

A billing code Q012 must accompany each submitted claim in order for the premium to be paid.

A physician who provides services on Recognized Holidays shall be entitled to receive payment of the After Hours Premiums for such services to Enrolled Patients.

3.9 New Patient Fee (Q013A)

The physician shall be paid $100 for each New Patient that is enrolled up to a maximum of 50 patients per fiscal year. For each such enrolment a Q013 must be billed in order for payment to be made. In addition, a 10% premium shall be added to this payment for those New Patients between 65 and 74 years of age and a 20% premium shall be added for those patients 75 and over.

3.10 New Graduate-New Patient Fee (Q033A)

A physician who qualifies as a New Graduate shall be eligible to receive the New Patient Fee of $100.00 for each New Patient that he/she enrolls up to a maximum of 150 patients during his/her first year of comprehensive primary care practice.

For the purposes of this Agreement, a New Graduate is a physician, including an International Medical Graduate, who graduated no more than three (3) years prior to the date that he/she signs the Agreement.

For each such enrolment a Q033A must be billed in order for payment to be made. In addition, a 10% premium shall be added to this payment for those New Patients between 65 and 74 years of age and a 20% premium shall be added for those patients 75 and over.

3.12 Unattached Patient Fee (Q023A)

An incentive in the amount of $150.00 will be paid to the physician on a per patient basis for the enrolment of patients who do not currently have a family physician and have had an acute care in-patient stay within the last three months. This fee is not payable in addition to the New Patient Fees set out in sections 3.9 and 3.10 of this Schedule. For each such enrolment a Q023A must be billed in order for payment to be made.

3.13 Diabetes Management Incentive (Q040A)

A physician shall receive an annual fee of $60 per Enrolled Patient for coordinating, providing, and documenting all required elements of care for diabetic patients.

In order to be eligible for this fee, the physician shall complete a flow sheet in respect of the diabetic Enrolled Patient that includes required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association 2003 Clinical Practice Guidelines.

3.14 Add-on Initial Smoking Cessation Fee (Q041A)

A Physician shall receive an annual incentive fee of $15 added to the normal visit fee for dialogue with an Enrolled Patient who smokes.

The physician shall document the smoking cessation dialogue by either referring to the Smoking Cessation Guidelines for Physicians and completing the Smoking Cessation Flow Sheet developed by the Ministry and the OMA or, alternatively, documenting the completion of the 5A model of the Clinical Tobacco Intervention program.

The Ministry shall pay the physician a maximum of one Add-on Initial Smoking Cessation Fee per Enrolled Patient per year.

3.15 Smoking Cessation Counseling Fee (Q042A)

A physician shall be entitled to an incentive for each of a maximum of two (2) follow-up counselling sessions in the twelve (12) months following the service date of a valid Add-on Smoking Cessation Fee (Q041A) for the Enrolled Patient who has committed to quit smoking. This incentive will be equal to the adjusted value of A007 over the term of the Framework Agreement, plus $1.50.

3.16 Rurality Gradient

A physician shall be eligible to qualify for a rurality premium on the basis of his/her score on the OMA RIO. Beginning at a score of 45 on the OMA RIO, a physician shall be eligible to receive a payment of $5,000 per fiscal year. This payment shall be increased by $1,000 for each further score of 5 on the OMA RIO.

For the purposes of determining eligibility for this payment, the physician's score on the OMA RIO shall be based on the location of the office in which the physician regularly provides the services set out in this Agreement (as registered with the Ministry).

3.17 Per Patient Rostering Fee (Q200A)

A CS physician shall receive an incentive in the amount of five dollars ($5.00) on a per patient basis for the initial enrolment of patients for the twelve (12) month period beginning upon the commencement his or her services as a CS physician. Such enrolment must be completed using the Ministry prescribed Enrolment and Consent Form as may be amended jointly by the Ministry and the OMA from time to time.

Note: In the event of any discrepancy between the contents of this Fact Sheet and the Ministry's template funding agreement(s), the terms and conditions of the Ministry agreement(s) shall govern the relationship of the parties.

APPENDIX B

QUESTIONS AND ANSWERS RELATED TO THE FAMILY HEALTH TEAM BLENDED SALARY MODEL FOR PHYSICIANS

---

1. Who is eligible for compensation through the Blended Salary Model?

The Blended Salary Model will be made available to primary care physicians employed by a community-sponsored or mixed-governance Family Health Team.

2. What are the proposed salary levels in the Family Health Team salary model?

There are three salary levels within the FHT salary model that correspond to specific target roster sizes, as follows:

Salary Level	Target Roster Size	Salary
Level 1	1,300	$130,793.71
Level 2	1,475	$148,296.50
Level 3	1,650	$165,799.30

Salary levels will be determined based on the physician's actual roster in comparison to target roster size as of March 31st of the previous fiscal year. In order to qualify for compensation at these levels, the physician must achieve the target roster size.

3. What happens if the roster size is less than 1,300 patients?

If a physician's initial roster of 1,300 patients declines, the physician will remain eligible for the level 1 salary until the roster number declines to fewer than 1170 patients. Below this point, the physician will be paid on a pro-rated basis. It is expected that the physician will continue to make best efforts to return the roster enrolment to 1,300.

4. What happens if the number of enrolled patients increases or decreases throughout the fiscal year?

Blended Salary Model physicians are expected at the outset to attain one of the three target roster sizes (1,300, 1,475, or 1,650) and then to sustain enrolment with as little variance as manageable around that target. A physician's salary will be at level 1 upon enrolling 1,300 patients, and will increase from level 1 to level 2 upon enrolling 1,475 patients, and from level 2 to level 3 upon enrolling 1,650 patients. The maximum salary paid for level 3 is $165,799.30.

If a physician's actual roster size decreases by greater than 10% of their target roster size, (i.e., from 1,650 to fewer than 1,485 at level 3 and from 1,475 to fewer than 1,327 at level 2), then the physician's salary may be adjusted to the next lower salary level for the next fiscal year. In the case where a physician's actual roster size decreases by greater than 10% of the first target roster size (i.e., from 1,300 to fewer than 1,170), the salary amount will be pro-rated on a per-patient basis proportional to salary level 1. Physicians are required to meet the established target roster size for their salary level within the upcoming fiscal year to maintain their current payments.

5. How will part-time physicians be compensated under the Blended Salary Model?

A physician who rosters fewer than 1,300 patients would be considered "part-time"; salary would be pro-rated on a per-patient basis proportional to salary level 1. Vacation entitlement would also be pro-rated accordingly.

6. How much vacation time are Blended Salary Model physicians entitled to receive?

As per the Community Health Centre (CHC) model, Blended Salary Model physicians providing 40 hours per week of service are entitled to receive 4 weeks paid vacation per annum.

7. What additional payments are blended salary model physicians eligible to claim?

Blended Salary Model physicians will be eligible to:

- Claim payments for services delivered per the incentives, premiums and special payments available in the Community Sponsored Family Health Team Contract;
- Receive payments for shadow billing (5% shadow billing premium);
- Earn a bonus payment of 8.69% of salary based on their success at minimizing the use of outside services by enrolled patients;
- Receive funding and support for information technology through OntarioMD based on physician FTE status;
- Receive reimbursement for malpractice insurance premiums not covered by the Malpractice Reimbursement Program based on actual insurance premium amounts;
- Bill fee-for-service for codes specific to the provision of emergency room unscheduled visits and obstetrical deliveries. Applicable codes include K990, K991, K992, K993, K994, K995, K996, K997, H055, H065, H101, H102, H103, H104, H105, H112, H113, H121, H122, H123, H124, H131, H132, H133, H134, H151, H152, H153, H154, H400, H401, H402, H403, H404, H405, H406, H407, H408 and P006, P020, E502, P018, P041, P042, E500, P038, P009, P010, P022, P023, P028, P029, P030, P036, P039, Z774, C989, E409, E410, E411, E414, Z775 and Z776. (Note: fee codes billed in association with the above 'K' codes are also considered excluded.);
- Bill fee-for-service for core services provided to non-enrolled patients within the Family Health Team to an annual maximum of $15,000, conditional on the physician fulfilling full-time hours of service to the Family Health Team;
- Bill fee-for-service with no limit for patient services provided to non-enrolled patients outside of the Family Health Team. conditional on the physician fulfilling their required hours of service to the Family Health Team; and
- Receive the benefits of all Harmonized Models, as per the 2004 Memorandum of Agreement.

8. When will physicians be eligible for compensation under the Blended Salary Model?

Compensation under the new Blended Salary Model will commence once a formal contract has been negotiated between the physician and CS and subsequently reviewed and approved by the Ministry and the Ontario Medical Association (OMA).

9. What is operational overhead?

Overhead for a typical family physician practice within a Family Health Team would generally include items such as rent, insurance[2], travel, supplies and equipment. Operational overhead is separate from, and does not form part of, human resources and/or transitional funding.

The Family Health Team receives payment for the average operational overhead costs of a practicing physician, and no additional payments will be requested from the physician for such costs. Please note: Physicians are ineligible to receive direct supplemental payments from the overhead component paid to the Family Health Team other than funds allocated for physician malpractice insurance and travel.

10. How will payments for salaried physicians be distributed?

Payments will be made to the Family Health Team and paid by the Team to the physicians as part of their physician services arrangement.

11. What are the eligible incentives, premiums and special payments available to Blended Salary Model physicians?

See Appendix A of this communication package for a full listing of additional payments as of April 1, 2006.

12. What are the after-hours obligations under the Blended Salary Model?

Each Blended Salary Model physician is required to be available for one 3 hour session from Monday to Thursday night (from 5:00 p.m. to 8:00 p.m.) or for a 3 hour session on the weekend. The Family Health Team may elect to commence After Hours Services on weeknights at a time later than 5 p.m., but no later than 7 p.m., and shall provide at least 3 full hours of After Hours Services on such nights.

Services delivered on Sundays can be counted towards achievement of the requirement of weekend after hours coverage. If both Saturday and Sunday services are provided, two 3 hour blocks of weekday after hours time would be considered to have been met.

If the Family Health Team consists of only one physician, at least one physician shall provide one block of after hours weekday, or weekend services, and if there are 2 physicians, at least 2 blocks of after hours are required to be covered.

For larger Family Health Teams comprising 5 or more physicians, a physician is required to be available for one 3 hour session on the weekend. In addition, the staffing of additional physicians may be necessary if the Family Health Team determines that this is warranted by volume and the needs of its patient population.

If more than 50% of physicians within the Family Health Team provide regular, ongoing emergency room coverage, anaesthesia services, or obstetrical deliveries, they may be eligible to receive an exemption from the Ministry for evening and weekend coverage upon written request.

---

[2] Physicians are eligible for reimbursement for physician malpractice insurance as part of the Ministry's agreement with the Canadian Medical Protective Association through the Malpractice Reimbursement Program. In addition to this provision, as employees, Blended Salary Model physicians are eligible for reimbursement through the physician overhead component of that portion of their malpractice insurance premiums not covered by the Malpractice Reimbursement Program. Such reimbursements for Blended Salary Model physicians will be based on actual, rather than projected, malpractice insurance premium amounts.

13. Will there be a physician fee-for-service billing limit for services provided outside the Family Health Team?

As in the CHC model, and conditional on the physician fulfilling their required hours of service to the Family Health Team, there will be no limit on fee-for-service billings for patient services provided outside of the Family Health Team. Outside services refers to services provided to non-enrolled patients in locations other than Family Health Team premises, or utilizing any of the support staff or services of the Family Health Team.

14. Will there be a physician fee-for-service billing limit for services provided to non-enrolled patients within the Family Health Team?

Core code services provided to non-enrolled patients are subject to a billing limit of $15,000 per FTE physician that will be pooled to establish a maximum value for each Blended Salary Model group within the Family Health Team.

15. Are special payments, premiums and incentive fees paid independently of roster size?

All special payments, premiums and incentive fees as per the Community Sponsored Family Health Team Contract are paid independently of an individual physician's roster size.

16. How are the cumulative preventive care management codes applied to the roster for physicians choosing the Blended Salary Model?

The service enhancement codes and corresponding fees are based on the percentage level of compliance with enrolled patients within the eligible target population.

17. Can new graduates bill new incentive fees?

New graduates are eligible to bill new incentive fee codes as long as they are not receiving income stabilization payments and meet all applicable requirements.

18. Do patient enrolment fees apply to new physicians compensated by the Blended Salary Model?

Yes, new Blended Salary Model physicians are eligible to receive the per patient enrolment fee, provided they have not previously received such fees for their patient in another model and/or they are not receiving income stabilization payments. In the case where a physician receiving income stabilization payments progresses to the Blended Salary Model, an appropriate retroactive payment will be made to recognize the physician's enrolling of patients.