Questions and Answers - **Group Contract for Practicing Full-Service Family Physicians**

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BRITISH COLUMBIA | Ministry of Health

General Policy Questions

1. **What is the purpose or objective of the contract model?**

   The group contract for practicing full-Service family physicians is intended to provide an alternative to fee-for-service (FFS) for established family physicians (FPs) providing full service longitudinal care. Contracts are at the clinic level. The contract was developed to:

   - offer more flexibility in practice compared to FFS;
   - promote work-life balance;
   - incentivize patient attachment;
   - incentivize ongoing quality improvement (QI); and,
   - facilitate the clinic's transition to the attributes of a patient medical home (PMH) and a primary care network (PCN).

2. **Who is eligible for the contract?**

   It is available for groups of three or more family physicians who are currently in practice with established panels and who work together in a clinic providing longitudinal care. It is also available to three or more individual physicians who are not in the same clinic but are located in the same PCN and are prepared to work together to provide the services under the contract. It is not available to solo practitioners.

3. **Are FP hospitalists who want to transition into primary care eligible for the contract?**
   In order to be eligible for the contract, the physician must have an established patient panel. FPs who do not currently have a patient panel, such as hospitalists, may access the Individual contract for new-to-practice (NTP) family physicians. The NTP contract provides income security while the physician builds their patient panel. At either the end of the contract term or once the physician feels that they have sufficiently established their panel, they may join the group practice contract.

4. **Do physicians need to be incorporated?**

   There is no requirement to be incorporated. Whether it is advantageous to incorporate or not is a matter that the physicians will have to determine on their own. Physicians may wish to seek independent legal and financial advice.

5. **Can physicians access employment opportunities outside the contract?**

   Yes, physicians may access employment and/or deliver services outside the scope of the contract. The contract deliverables are generally focused on in-clinic services delivered to attached patients. Physicians may choose to work in other practice settings and be compensated for those services separately; however, physicians should ensure that they are able to continue to meet their obligations under this contract prior to committing to other opportunities.

6. How does this model differ from FFS?

Under both payment models, FPs are independent, autonomous practitioners; however, the contract better supports the PCN and team-based care. Under FFS, physicians are paid a specified amount for providing services in accordance with the Medical Service Commission payment schedule; at present, there are billing restrictions on delegating services and limited ability to bill for team consultations.

Under the contract, time spent delivering services is a major component of payment. Compared to FFS, contracted physicians have a more stable and predictable income, which enables them to spend more time with patients and to work in interdisciplinary teams.

7. Do clinics need to be part of an established PCN to be eligible to access the contract?

In order to access the contract physicians must participate in an existing PCN or commit to actively support the development of a PCN in the community and they must agree to provide community longitudinal primary care services aligned with the principles of a PMH. There is no ability for a clinic to opt out of a PCN and remain on, or onboard to the contract.

The contract is available to all group clinics who meet the criteria, but priority consideration will be given to physician groups in communities with PCNs with approved plans and implementation underway.

8. Can the contract be used in clinics that serve vulnerable, marginalized, or mental health and substance use populations?

Generally, the contract is targeted towards group practices that provide longitudinal primary care for a panel of patients. In developing the contract, the ministry's assessment showed that the type of care required by especially vulnerable populations, and the often highly focused nature of these types of practices, may not be best compensated under the contract.

For example, it may be more difficult for focused practices to qualify for higher panel size/complexity premiums, and physicians working with vulnerable populations often work less than the 0.5 full- time equivalent (FTE) required under the contract. However, clinics serving vulnerable or targeted populations are eligible to express interest in the contract if they feel it may be a good option for them.

9. Does the contract allow group practices to attach patients to the group, rather than to individual FPs?

For the purpose of ongoing contract payments, attachment is considered at the group practice level. However, within the group practice, attachment is established between a

patient and an individual physician through an attachment conversation which outlines the expectations of each party.

10. Are NTP physicians eligible to access the contract?

Physicians without a patient panel who join a clinic on a group contract for practicing full-service FPs will have the opportunity to sign on to the NTP contract while they build their patient panel.

In such circumstances, the physicians working under the group contract will sign a practice agreement, which is included as part to the NTP contract. At either the end of the contract term or once the physician feels that they have sufficiently established their panel and the ministry agrees, they may join their clinic's group contract.

11. Can a group of previously unaffiliated physicians come together to access a contract to establish a new clinic?

Yes, previously unaffiliated physicians can agree to work together as a group under the contract, provided there is an intra-physician governance agreement established outlining how they are to work together to meet the obligations of a group practice (e.g., cross coverage, share the same EMR, etc.). For a guideline on what should be included in such an agreement, please click here.

12. How will other clinic team members be compensated?

Clinics that sign on to the contract may hire additional clinic staff at their discretion and are responsible for compensating any hired staff through the contract funding amount. PCN-funded resources may be available where PCNs have been approved and implemented. These resources are deployed at the local PCN level.

13. How does it work if there are other practitioners in the clinic who have panels but are not on the contract, for example a nurse practitioner (NP), or a physician who is building their panel but not included in the clinic contract?

If there are other practitioners in the clinic on individual contracts, such as NPs or physicians on the NTP contract, those practitioners are paid separately according to the terms of their contracts. Those practitioners' patients are not counted in the analysis of the clinic panel for the purposes of calculating the panel/complexity payment.

Physicians working under the group contract will be required to sign a practice agreement with the NTP physician. When a physician working under the group contract provides a service to a patient of the NTP physician, the Physician will not be eligible to bill FFS. Rather the time spent providing such a service is billable under the group contract.

Contract Model: Provisions

14. Is there a term to the contract? What happens when the term ends?

The term of the contract is three years, with a provision that allows a physician to terminate the contract with six months' written notice. At the end of the contract term the contract may be renewed. If either party (physicians/health authority) wishes to renew the contract, they must provide written notice to the other party no later than 90 days prior to the end of the term. If either party wishes to terminate the contract before the end of the term, they may do so by providing six months written notice.

15. Are the contracts with the ministry directly or with the health authorities?

The regional health authorities are the contract administrators. As part of the contract model, the ministry will have certain obligations to support the health authority in the administration of various components of the contract, including payment calculation, reconciliation, and audit.

16. Who are contracted physicians managed by or accountable to as they are paid by the health authority but working in the group practice?

As independent contractors, physicians providing services under the contract are required to meet the deliverables and obligations of the contract (e.g., provisions of full service primary care, hours requirement, reporting, group practice hours, etc.); however, as contractors physicians have the autonomy on how they manage their group practice and meet the deliverables and obligations of the contract.

17. What level of insurance are contracted physicians required to have?

The contract requires that the physician have comprehensive or commercial general liability insurance of no less than $2,000,000 if they own or rent the premises where the services will be provided. The physician must also have adequate professional liability coverage for a FP through Canadian Medical Protection Association or a comparable insurance plan.

18. What happens if the group practice is unable to meet their committed hours of service or contract FTE for the year?

If the group practice is unable to meet their committed hours of service or contracted FTE for the year, the contract amount, including any year one income guarantee amount, will be prorated based on the number of hours reported (one FTE is 1,680 hours). The proration will occur on the entire assessed contract amount.

19. What happens when a contracted physician goes on maternity leave?

Physicians who are absent from practice due to maternity leave or for any other reasons

(e.g., parental leave, sick leave, etc.) are required to arrange coverage for their patients. This may occur through cross coverage by other physicians within the practice or through the use of locums.

20. How does locum coverage work for physicians who sign on to the contract?

Physicians may arrange for locum coverage if necessary. There is no separate, additional funding included with the contract to support locum coverage.
Where a locum physician is providing services and reports their hours as hours under the contract, the contracted physician is responsible for paying the locum from the amounts paid under the contract. If the locum bills FFS for services provided under the contract, the locum cannot report their hours under this contract.

The physician may request locum coverage through existing programs, i.e. the Rural General Practitioners Locum Program, if they are eligible, in which case the locum will be paid according to the provisions of the applicable program.

21. Am I able to subcontract to another physician?

Yes, each physician may, with the written consent of the health authority, subcontract or assign any of the services. The physician will be required to ensure that any contract between the physician and a subcontractor complies with all relevant terms of the contract, including signing a FFS waiver in the form set out at Appendix 4. The physician is required to provide a copy of the FFS waiver to the health authority prior to the subcontractor providing any services under this contract.

22. What is the process for a physician to join or leave a group practice when the physicians are on the contract?

Any new physician added to the contract, who is not an initial signatory, is required to sign and deliver to the others an acknowledgement and agreement using the form set out in Appendix 7 (New Physician – Agreement to Join). The form provides a formal acknowledgement of the new physician's agreement to become party to the contract and be bound to contract terms.

In the event a physician chooses to leave the group practice, they are required to provide the health authority with written notice six months prior to leaving. An information copy of the notice must be provided to the remaining physicians at the group practice as well.

The health authority is required to notify the ministry within 30 days of any physician departing from the contract physician group.

23. What is the FTE definition under the contract? Is there a minimum or maximum FTE?

The contract defines 1.0 FTE as 1,680 to 2,100 hours of direct or indirect clinical care, clinical administration services per year. There are also provisions to include limited amounts of clinical research, and QI time under contract hours. The maximum FTE a physician can work under the contract is 1.0 FTE and the minimum requirement under the contract is 0.5 FTE (840 hours). The group practice is required to have at least the same number of physicians as contract FTEs.

24. Are there any restrictions to the number of days or hours a physician must work under the contract?

To ensure continuity of care for patients, each contract physician must commit to distributing their hours of services equitably over the course of each year of the term, and no physician must work greater than 90 hours bi-weekly. Additionally, each contracted physician group is responsible to determine the minimum clinic hours of business with the health authority and participate in any after-hours arrangements organized through their local PCN, or local PCN in development.

25. Are physicians able to use virtual care options (e.g,. telehealth) to deliver services under the contract?

Physicians can deliver services under the contract via face-to-face appointments, telephone consultations and virtual care options, where available, and as appropriate based on the clinical circumstances.

26. Will contracted physicians be penalized if their attached patients seek primary care services elsewhere?

No, physicians will not be penalized if their attached patients seek primary care services elsewhere. However, the ministry will monitor the related reporting that a physician submits on the size and complexity of their patient panel, and the access provided to attached patients.

27. Is there a ratio of direct patient care to indirect patient care, clinical administrative services, and/or other services specified in the contract? How are these service types defined in the contract?

No, there is no defined ratio of direct patient care to indirect patient care, and/or other clinical administrative services specified in the contract. Services under the contract include both the full scope of primary care services as well as clinical administrative services, such as: medical co-ordination, QI, participation in multidisciplinary team planning, and participation in the planning of long-term health care delivery goals and health prevention and promotion activities as part of the PCN. Other services may be included as part of the practice agreement between the practitioner and the practice.

Contract Model: Services

28. Are physicians who sign on to the contract expected to provide extended hours of service?

Physicians are required to abide by the College of Physicians and Surgeons of British Columbia's practice standards regarding access to medical care. There are no specific contractual obligations to provide extended hours of service, however physicians are expected to coordinate with the health authority and other practitioners in the PCN in order to provide flexible scheduling as required for extended hours of service within the PCN, when and if the physicians agree to provide such extended hours of service.

29. Are physicians who sign on to the contract required to provide on-call coverage?

Family physicians are part of one or more clinical network teams working together to meet the comprehensive care needs of their patients and the patients of other PMHs in the community including extended hours of service, cross coverage and/or on-call. However, the contract does not address the specifics of on-call coverage requirements for patients within the group practice; this is a matter for the practice to coordinate. The time while on call does not count towards contract hours; however, the time providing services while on-call can be included in the hours worked under the contract.

30. Are physicians required to perform all of the services listed in Appendix 2 of the contract (e.g., immunizations, harm reduction, etc.)?

The services listed in Appendix 2 of the contract outline the "primary care services" that are compensated as hours under the contract. Contracted physicians are not required to perform all services listed in Appendix 2, but if the service is provided the hours are to be included in the hours of Services under the contract. For example: childhood immunizations may be performed by population and public health rather than in-clinic, however if that service was provided in the clinic, it would be reported as hours under the contract.

Physicians are expected to provide these services where reasonably possible; physicians on the EFP contract are encouraged to utilize cross-coverage where required. If a physician is unable to provide a service listed under Appendix 2, a physician may refer the patient to a different provider for the service.

31. What are the deliverables of the contract?

The deliverables of this contract focus on direct and indirect clinical primary care activities, QI activities, and clinical administration provided by the physicians in-clinic. The scope of services described in Appendix 2 of the contract are designed to support full scope

longitudinal primary care. Physicians must commit to reporting hours, access measures and QI activities, which will determine if the deliverables have been met.

32. What happens if a physician is unable to meet one or more deliverables?

Generally, if a physician is having difficulties meeting a contract deliverable, the expectation is that they work with the health authority and their group practice to identify strategies to address the difficulties and meet the deliverable going forward. There are specific deliverables that are expected in order to earn the full value of the contract. The deliverables include meeting the QI requirements, performing the hours of work, and maintaining attachment and encounter reporting.

33. What is the expectation for inpatient care within these contracts?

Only in-clinic primary care services are in scope under the contract. If a physician provides inpatient care to their patients, they can bill FFS for those services.

34. How does the contract define longitudinal, full scope primary health-care services?

Under the contract longitudinal, full scope primary care services refers to comprehensive, accessible, interdisciplinary, patient focused primary health care that aligns a physician's practice with the attributes of the PMH. Physicians will use the principles of population health for prevention, identification and management of chronic illness including addictions and mental health.

Primary care services also include health promotion and illness prevention activities, care for minor or episodic illnesses, chronic disease management, management of patients care across primary, secondary and tertiary care, reproductive care, mental health and substance use services, terminal illness care and coordination and access to rehabilitation. In addition, clinically related research and teaching to medical students and residents that is concurrent with direct and indirect patient care is also included.

35. What activities can be included as billable contract hours?

Time spent on activities that can count towards contract hours include primary care services, including but not limited to: direct and indirect patient care, clinically related teaching and research, and clinical administrative services delivered in-clinic. QI activities of up to one hour per week per contract FTE may also be reported under contract hours.

36. Does training and/or group practice orientation count towards the contract hours?

Providing or receiving group practice orientation does not count towards contract hours.

37. Does attendance at division and/or PCN meetings count towards the contract hours?

No, attendance at division and/or PCN meetings does not count towards the contract hours. The Doctors of BC and the General Practices Services Committee (GPSC) may provide funding for physicians to attend these meetings.

Contract Rates, Benefits and Eligible Payments

38. What components comprise the contract payment structure?

The contract payment structure consists of two payment streams divided into five potential contract bands. The bands and streams are illustrated in the table below, and each component is described in the following questions. Understanding how the contract value per FTE is determined requires understanding how the components work.

The contract bands pay one of five amounts follows (as of April 1, 2021):

Contract Band	Patient Panel Size/Complexity Overall Weight	Initial Contract Value for 1.0 FTE	QI Component	Contract Value for 1.0 FTE
Band 1	100.1% - 103.4%	$275,057	$20,400	$295,457
Band 2	103.5% - 106.8%	$285,257	$20,400	$305,657
Band 3	106.9% - 110.3%	$295,457	$20,400	$315,857
Band 4	110.4% - 113.8%	$305,657	$20,400	$326,057
Band 5	113.9% +	$315,857	$20,400	$336,257

39. What are the payment streams under the contract?

The contract has two payment streams:

- *Panel and Complexity Payment:* an hours-based payment, based on physician hours worked delivering direct or indirect patient care, on a per FTE basis. (1.0 FTE = 1,680 to 2,100 hours in a year). A minimum number of hours must be worked per 1.0 FTE and reported to earn the full basic payment (prorated for partial FTEs). The rate per FTE paid is based on how the group's panel size and complexity compares to a panel size expectation as set out in the contract. The base payment rate per FTE is $275,057per FTE. The Panel and Complexity payment increases in $10,000 increments up to $40,000 per FTE when the groups patient complexity and panel size is higher than the panel size expectation of average complexity patients.

- *QI payment*: payment for completion of select QI activities by each physician. The group practice's QI payment will be decreased for each physician failing to complete their QI requirements. The QI payment is $20,400 per 1.0 FTE, prorated for partial FTEs.

40. What are the requirements to earn the QI payment?

Each clinic physician must complete a minimum of four QI activities for the clinic to receive the $20,400 per 1.0 FTE. This includes mandatory QI activities, and a minimum of two additional QI activities for physicians committing to 0.75 FTE and above and one additional QI activity for physicians committing to less than 0.75 FTEs.

The mandatory QI activities are:

- Implementing and using the GPSC patient experience tool through the Practice Support Program; and,
- Engaging in the three phases of panel management, and panel maintenance.

Two additional QI activities from a list of seven optional activities listed in the contract must be completed each year by physicians intending to work 0.75 FTE or greater under the contract. Physicians intending to work fewer than 0.75 FTE are required to do one additional QI activity.

41. If a physician does not complete the QI activities, how is the group practice's payment affected?

The group practice's payments are reduced for each physician not completing the QI requirements. If the group practice engages a locum or sub-contracted physician to fill in for a physician on leave, the group practice physicians are responsible to ensure the locum/ contracted physician completes the required QI activities.

42. How is the payment for panel complexity calculated?

The panel and complexity payment is related to the group practice's patient panel size and complexity. Panel size is determined through the number of attached patients and complexity is measured through the Adjusted Clinical Groups (ACG) measures defined by the Johns Hopkins ACG classification system.

The group practice's panel size and complexity are compared to the expected panel size and average ACG throughout B.C. to determine an overall complexity weight.

Where the group practice's overall weight is greater than the expectation, a payment is available based on four bands of percentage ranges above the average range.
The payment is applied as a percentage to the base payment. Percentage ranges above 100% are divided into contract bands for allocating the premium in $10,000 increments to a maximum of $40,000 per FTE in the contract.

43. How is the contract rate determined for the first year of the contract term?

The first-year contract amount is guaranteed, provided contract deliverables are met. The income guarantee is equivalent to the group practice's historical FFS income for clinic-based services (excluding third-party billings), up to a maximum of $336,257 per FTE in the contract.

Where a group practice's historical earnings are less than $275,057 per FTE (the minimum contract amount per FTE), the income guarantee will be $$275,057 per FTE. Group practices are eligible for an additional $20,400 per 1.0 FTE, prorated for partial FTEs, for completion of QI activities.

44. How does the year-end reconciliation process work?

Reconciliation of the contract year's payments is completed within 120 calendar days of the contract year end. The reconciliation considers the amounts paid over the completed contract year, comparing them to the contract income generated by the group practice's actual activity - taking into consideration QI activities, physician hours worked up to 1.0 FTE as defined in the contract, and attached patient numbers and complexity - and reconciles any differences between the two calculated income amounts.

45. What benefits and entitlements are physicians entitled to when they sign on to the contract?

Each physician is entitled to access the benefit plans as defined and described in the Benefits Subsidiary Agreement under the Physician Master Agreement (PMA). These benefit plans include:

- Continuing Medical Education Fund
- Physician Disability Insurance Program
- Canadian Medical Protective Association Rebate Program
- Contributory Professional Retirement Savings Plan (CPRSP)
- Physician Health Program
- Parental Leave Program

On April 1, 2021, contract band rates were adjusted by 2.0%. From April 1, 2022, contract band rates will increase based on agreement between the ministry and the Doctors of BC as part of future PMA negotiations.

Additionally, each physician participating in the contract is entitled to access the benefit plans as defined and described in the Benefits Subsidiary agreement under the PMA. The CPRSP is included under the Benefits Subsidiary Agreement.

46. Are contracted physicians eligible for rural retention premiums and other rural programs?

Yes, the physicians' eligibility for the Rural Retention Premiums and other rural programs remain unchanged.

47. Which GPSC incentives, if any, are contracted physicians eligible to bill and/or receive payment for?

The following GPSC Fees and payments may be billed and retained by physicians' party to the contract:

- H14086 FP Assigned In-Patient Care Network Initiative
- FP Unassigned In-Patient Care Network Incentive (adjustment code 'GU ')
- H14088 FP Unassigned In-patient Care Fee
- H14010 Maternity Care Network Initiative Payment
- Any payments under the GPSC's Long Term Care Initiative.

48. What funding is provided to cover clinics' overhead costs?

Similar to FFS, which is an all-in payment amount inclusive of overhead, the contract funding amount is also inclusive of funding for overhead.

49. How are third party and other FFS billings provided either in clinic or outside the clinic reported to minimize the risk of being flagged for audit?

Physicians may bill for third party services (e.g. WorkSafeBC or ICBC) and other services outside the scope of the contract; however, the time spent providing these services cannot count towards the contract hours. The contract recognizes that the above noted FFS services may be provided during group practice hours or outside the group practice on the same day. A reporting mechanism has been developed to facilitate accurate reporting of hours and to minimize the risk of being incorrectly identified for audit.

All FFS billings by physicians on a day where they work contract group practice hours must be submitted to Teleplan with start and end times and time spent on in-clinic activities billed FFS must be reported separately on the hours reporting template.

50. Can contracted physicians bill FFS when a patient who is not attached to the group practice is referred by a practitioner from outside the group practice?

Yes, physicians may bill FFS for services provided to patients referred to the physician by a primary care provider from outside the contracted group practice for specialized services (such as obstetrics), the patient is not and will not be attached to the physician's group practice. The time spent providing these services to these patients must not included in the hours reported under this contract. These FFS billings must be reported in the same manner as other FFS billings, billed against the group practice payee, and must include start and end times when entered in the MSP Teleplan System.

Reporting and Measurement

51. Does FFS work undertaken on the same day as work under the contract need to be reported on the hours template?

Yes. When FFS work is undertaken on the same day as work under the contract, time spent delivering services outside the contract must be deducted from the total number of hours in the shift reported on the hours template. There are specified fields on the hours template to accommodate these instances. The total number of hours billed to the contract for the day in question must not include any time spent delivering services outside the contract, such as those for which the physicians are entitled to bill FFS.

All FFS billed on the same day as a contracted shift must include start and end times of the patient encounter on the FFS claim and must be reported on the hours template. Any FFS billed outside of the group practice (e.g., doctor of the day) but on the same day as a contracted shift, does not need to be reported on the hours reporting template but the FFS billings must include start and end times of the patient encounter.

The ministry will provide guidance on all reporting requirements under the contract.

52. What information do contracted physicians need to report via Teleplan?

Contracted physicians are required to submit the following elements through Teleplan:

- Simplified encounter reporting (service-level reporting, where a service is provided during a contract hour);
- Attachment reporting ($0 administrative fee code, where attachment has been established with a patient through an attachment conversation);
- Shift reporting ($0 administrative fee code, where a clinic shift is worked by the physician).

The ministry has drafted a detailed guidance document on Teleplan reporting which will be available to physicians.

53. How are hours reported? What level of detail is required?

Physicians report their hours worked under the contract to the health authority by using the hours reporting template provided by them. The template includes physician-level details, and clinic-level summary details.

Service types include direct care, indirect care, and clinical administration for all regular hours reported under the contract. For all excluded services (services compensated outside the contract) and QI activities undertaken during the contract shift, a separate entry is required in the reporting template.

The ministry has drafted a detailed guidance document on the hourly reporting under the contract, which will be made available to physicians.

54. What information do contracted physicians need to report to the health authority?

On a quarterly basis, contracted physicians are responsible for reporting their contract hours reporting templates, patient access metric templates, and details of the disbursement of the funding among the physicians in the group to the health authority. Contracted physicians are also required to notify the health authority of any changes to clinic staffing, including the use of locum physicians.

55. How will patient access be measured and reported?

The contract uses time to third available appointment as a measure of patient access. Physicians in participating clinics are responsible for tracking this measure monthly, using a ministry constructed template and with the assistance of the Doctors of BC Practice Support Program, and reporting results to the health authority on a quarterly basis.

56. How is patient attachment established, reported and confirmed?

Patient attachment is established through an attachment conversation between a physician and a patient, as outlined in the contract. For each attached patient, the physician submits an attachment record for the patient through Teleplan. The attachment records are valid for a period of one year. For more information on attachment reporting, please see the guidance document on the PCN Toolkit at: https://www.pcnbc.ca/en/pcn/permalink/pcn90.

The contract also requires physicians to provide patients with information about how they may confirm their attachment with the ministry. The ministry is currently working on an electronic mechanism to enable patients to confirm their attachment; however, n the interim, the ministry will provide group practices with a standardized form for patients to sign and submit to the practice for safe storage.