**TITLE:** GPSC Incentives Briefing Note 2/3: Simplifying & Aligning Current Incentive Fees

**DATE:** April 24, 2017

**PREPARED FOR:** General Practice Services Committee

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**PURPOSE:** [ ]   *Discussion* [ ]   *Consultation* [ ]   *Information* [x]  *Decision*

**ISSUE:**

The Incentives Working Group (IWG) seeks a decision on proposed changes to the current GPSC Incentives fees. The proposed changes respond to the extensive feedback obtained during the GPSC Visioning process and aim to simplify fee rules and administration, and improve consistency across fee rules, as appropriate. The following proposals can be implemented relatively quickly. A summary of recommended changes is provided below. Detailed descriptions of the recommended improvements for each set of fees, as well as the budget implications, can be found in the appendices.

**BACKGROUND & DISCUSSION:**

**Guiding principles for the overall redesign of GPSC incentives (approved by GPSC Core, March 17, 2017)**

As the IWG moves forward with reviewing and redesigning the GPSC incentives, several guiding principles have been identified. These principles are evolving as the iterative nature of the design process identifies new priorities for simplifying the incentives and aligning with the Patient Medical Home.

* A holistic approach to redesign to facilitate consistency and budgeting across all fees.
* A simplified fee structure and guides to help physicians to utilize the fees.
* Fees should be created to support Team Based Care, which encompass the target populations contained in the PMA.
* Payment is graduated relative to the complexity and level of effort to treat the patient.
* Complexity is based on functionality of patient rather than a particular diagnosis.
* Changes to incentives are communicated to physicians in a timely and informative manner.
* Fees are auditable.

**Summary of Changes for GPSC**

Note that the Maternity Care, In-Hospital and Residential Care Incentives are not included in the proposed changes.

Please refer to Appendix 3 for a summary of projected cost implications.

Specific goals of the following changes:
(1) simplify and align similar fees to make the billing rules consistent and easier to understand
(2) allow for provision of some aspects of care required for incentive billing to be provided by allied health professionals (AHPs) to better support team-based care (TBC)
(3) ensure that changes allow for appropriate audit.

Chronic Disease Management Fees 14050 14051 14052 14053

Billing of these fees currently requires two visits in the previous 12 months, one of which may be by telephone (and therefore could be provided by a nurse because 14079 and 14076 may be delegated.)

RECOMMENDATION A: To further enhance support to TBC, a $0.01 value encounter code will be used to allow an in-person visit with a college certified AHP to be recorded and counted as one of the two required visits. The FP would likely see another patient during the AHP in-person visit; the budget impact is likely to be cost avoidant for these patients, while increasing access for other patients resulting in overall net neutral impact on cost.

Does GPSC want to state that one of the two required visits MUST be with the physician?

Complex Care 14033, 14075; Mental Health 14043; Palliative Care 14063 Planning Visits

IWG recommends these all be considered planning fees with consistent requirements for face to face time; whether another visit service must or may be billed on the same day; use of AHP for provision of some of the services etc.

RECOMMENDATION B: Separate out the planning visit component of the Complex Care fees and align requirements and value to that of the Mental Health and Palliative Care fees. The current fee is $58 million in 2016. Reduction of the fee by $215 will lead to an estimated $40 million in savings. Utilization may be less as well.

RECOMMENDATION C: For all three fees, a same day visit service may be billed on the same day as the planning visit fee for any reason. No material cost change anticipated.

RECOMMENDATION D: The required 30 minute planning time does not all have to take place on the same day. No material cost change anticipated.

RECOMMENDATION E: The majority of the required 30 minutes must be face to face with the physician for all planning fees. No material cost change anticipated.

With these changes, there will be no change to the current diagnostic criteria for the planning fees. The separation out and payment only for the planning component of Complex care will result in ~ 2/3 of the current expenditure becoming available for reallocation. The IWG is considering a recommendation to expand access to complex care planning fees to more patients with complex conditions that is based on functionality of patient rather than a particular diagnosis as per guiding principles from GPSC. Please see Briefing Note 3/3 (April 24, 2017) for an update on this work.

Mental Health Management 14044/45/46/47/48

GP Telehealth counselling fees are available in the FFS budget, meaning that the current MSP maximum of four 0120 fees per patient/calendar year can be provided by any combination of in-person or video services. The GPSC Mental Health Management incentive currently allow 4 additional counseling equivalent fees for in-person counselling visits for patients on whom a MH planning fee has been billed, once the 4 MSP codes are used.

RECOMMENDATION F: To align with the current MSP counselling visits, GPSC mental health management fees 14044-14048 should include access by videoconferencing. None or small budget impact likely.

Telephone 14076 and Email 14079There is a lack of appropriate relativity between 14079 and 14076, both of which pay the same amount but without the same restrictions on delegation or purpose (medical management vs. follow-up). The SSC has separate codes paid at different rates for telephone advice vs email advice to patients.

RECOMMENDATION G: Delete the 14079 and remove reference to it in the planning fees and 14053. This would reduce budget by approximately $500,000. Replace 14079 with a new email/text/telephone relay fee 140XX applicable to all patients and delegable to AHPs, including MOAs.

RECOMMENDATION H: The 14076 and 140XX will not be billable on the same patient on the same day nor would they be billable on the same day as an in-person or video visit.

RECOMMENDATION I: Set consistent annual limits on the number of billable 14076 and 140XX per calendar year.

RECOMMENDATION J: Increase the value of 14076 to $20; this increase would increase the budget by approximately $2M. Set the value of the new 140XX to $10; this new few is expected to cost $330,000.

GP with Specialty Training Telephone fees 14021, 14022 and 14023RECOMMENDATION K: Align 14023 with the 14076: make it worth the same, new value ($20) and delete the per 15 min component. This reduction in 14023 would create approximately $15,000 in savings.

Conferencing fee 14077; 14015, 14016, 14017The 14077 conferencing fee supports physician participation in TBC and we propose no changes.

RECOMMENDATION L: IWG will review utilisation of 14015-14016-14017 to determine if they can be deleted. Deletion of these fees would create approximately $400,000 in savings.

RECOMMENDATION M: Once utilisation of 14015-7 is reviewed, if they are to continue, align them with 14077 by removing wording that refers to the time spent doing paperwork and conferencing with family.

**Budget Implications**

See appendix 3: GPSC Fee Projections for more details on projections of current fees and budget implications for each of the recommended fee changes.

**Communication to FPs**

The proposed changes are a response to the feedback received during the extensive engagement of FPs that occurred during the GPSC Visioning process. The timing of the announcement of changes is included for discussion and decision in Briefing Note 1.

**DECISIONS REQUIRED**

Separate GPSC approvals are requested for each of Recommendations A to M above.

**IS THIS IS A FUNDING REQUEST?**

[ ]  No [ ]  Yes

If yes, *where applicable identify other funding sources/amounts:*

|  |  |
| --- | --- |
| **Source** | **Amount** |
|  |  |
|  |  |
| **Total** | **0** |

**Appendix 1: GPSC CDM/Complex Care Incentive Revision Option Proposals**

1. **Support for Team-based Care – Identification of services provided by non-physicians**

While GPSC reviews possible funding changes to support the move to the PMH and team-based care, some FPs may not want to change funding models. Regardless, there are some changes that could be made in the short and medium term to make enable existing GPSC incentives to better support team based care.

To support these changes and allow ***electronic auditing, it will be necessary to develop a $0.01 encounter code for use when a college certified allied care provider*** is involved in providing care to patients. . This code would be used whether the Allied Care Provider is an employee of the family physician/PMH or is a Health Authority funded ACP embedded within the PMH.

1. **Planning Visits (G14033/75, G14043, G14063)**

GPSC has 3 sets of planning visit fees: Complex Care (G14033/75); Mental Health (G14043); and Palliative Care (G14063). Planning visits are intended to support informed discussions of the patient’s medical conditions and care plan including the patient goals of care and make shared decisions on how (or whether) to apply e evidence informed guideline recommendations. Advance Care Planning is an element across all three types of planning visits depending on patient status.

All three planning incentives allow the planning to be done with the patient and/or the patient’s medical representative but require in-person time with the physician. The time for any additional same day visit service is not included in the planning time:

1. Complex Care Planning **requires** a same day visit service to be billed.
2. Mental Health Planning **allows** a same day visit service to be billed only if a longer specified time is spent.
3. Palliative Care Planning says a visit **may** be billed, but does not specify this visit is required or that it is only billed after a specific amount of time is spent.

Each of these planning visits has different and difficult to understand time requirements.

1. Complex Care Planning requires 30 minutes for the planning visit, review of information and creation/documentation of the resulting plan. The majority of the planning time must be in person with the patient/medical representative, but non-face-to-face components may be done at other times, even on a different day. Start and end times do not need to be submitted. Chart documentation must include total time spent and face to face time spent.
2. Mental Health Planning requires all of the 30 minutes to be face to face. Review of information and creation/documentation of the resulting plan is not included in this face-to-face time requirement. If the time spent face to face is at least 40 minutes, a visit fee is billable in addition. If the time spent face to face is at least 50 minutes (and the preamble to fees rules for counselling are fulfilled) a counselling fee is billable in addition. Start and end time of the total encounter must be submitted with the claim and documented in the chart.
3. Palliative Care Planning requires all of the 30 minutes to be face to face. A visit fee (home or office) is billable on the same day when more than 30 minutes is spent, but unlike G14033/75, the fee does not specify “A medical visit (in office or home) or CPx fee must be billed for same date of service. “

There are two issues for GPSC to consider in reviewing and possibly revising the planning fees:

1. **Alignment across all Planning Incentive Fees:**

To align across all Planning incentives, GPSC should consider separating out the planning visit component from the Complex Care incentives and then make the requirements consistent across all planning fees. This includes both the same day visit billing allowance or requirement, as well as the time requirements. Feedback has been that requiring 30 minutes face-to-face at one visit is not realistic for some patients who would benefit from a planning visit (e.g. dementia, schizophrenia, frailty, etc). For some patients, a significant amount of time is spent coordinating patient care, which is not provided face-to-face. From a work flow perspective, this planning work is often best split between two sessions - for example, one to review what has happened since the last planning visit and arrange any investigations needed, and one to review the results of those investigations and discuss the care needs for the coming year.

1. **Support for Team Based Care:**

In TBC models, it may be appropriate to have an allied care provider undertake some of the components required for a care plan review/development. Currently the time requirements for the MH and PC incentives are all physician time requirements. GPSC allows delegation of telephone follow-ups with patients to allied care providers (14076 and 14079). A 14076 or 14079 service counts as one of the two visits in the previous 12 months required for payment of a CDM incentive. GPSC could similarly approve the delegation of a portion of the planning process to a College Certified Allied Care Provider as qualifying toward the total planning time required.

The proposed revisions for consideration are:

* All planning visits to have same rule on whether or not a same day visit service fee is billable in addition to the planning incentive. If a visit fee is not billable in addition to any planning fee, need to consider circumstances when the planning visit occurs at home with a home bound patient, and any unintended consequences of a “no visit in addition” rule.
* Allow split of the planning process into 2 sessions, which must add up to the 30 min requirement. A Visit fee would be billed for the first segment of the planning process if provided by FP or an encounter code submitted if provided by ACP. For example, the RN reviews events of the year, medications and need for any labs, ensure patient has any additional testing done (first part of planning fee). Then the patient returns to see FP for balance of planning visit, on which day the incentive fee is submitted (+/- visit fee as per above).
* All Planning visit fees should have the same value based on the total time requirement consistent for all. Require that majority of total time is physician-patient/representative in person, but allow balance to be provided by ACP.
1. **Complex Care Incentives (G14033, G14075)**

The initial Complex Care Incentive was developed as a result of the 2006 Working Agreement to provide recognition that patients with co-morbid conditions require more time and effort to provide quality care, and to remove the financial barrier to providing this care. The value of the fee was determined by including: $100 for the initial planning visit billed in addition to the visit fee; $75 for a review of the plan, also billed in addition to the visit ; and $35 as a top up to 4 subsequent office visits.

The initial version of the complex care initiative had two options – a “bill as you go” when providing individual components of the complex care incentive OR a one-time payment that combined the maximum value of all components as prepayment for the time, intensity and complexity of caring for the patients for the balance of the year. After one year, this was simplified to a single payment option: the full $315 was billable in addition to an office visit for the complex care planning visit once per calendar year. This block of funding included the $100 planning service and prepayment of $215 ($75 plan review plus $35 x 4) for additional time/intensity/complexity over the balance of the year.

Currently the Complex Care Incentives, G14033 and G14075, do not reflect the actual complexity burden in any given family physician practice because of their restriction to specific diagnoses. Separating out the planning visit fee of $100 from the current complex care incentive fees would allow the reallocation of roughly 2/3 of the total Complex Care Expenditures to the provision of a planning service to a much broader patient population.

1. **Chronic Disease Management Incentives G14050, G14051, G14052, G14053:**

Currently the GPSC CDM incentives are disease specific for Diabetes, Heart Failure, Hypertension and COPD. Revisions to the fees could align CDMs to better support team-based care.

Current requirement is for 2 “visits” in the 12 months prior to submitting Annual CDM incentive. At this time, at least one must be an in-person visit between the physician and patient. The other required “visit” can be a group medical visit or a telephone management visit 14076 or 14079. Group medical visits (MSP fees) already allow the use of allied care providers as part of the team providing the GMV. Telephone calls (both G14076 & G14079) may be delegated to College Certified Allied Care Providers, although G14079 may also be delegated to the office MOA (to relay the clinical information provided by the physician). In this way, the CDMs do support team based care, but this could be expanded to include a visit with the PMH ACP (with $0.01 encounter code submitted) as an alternative to the GMV or telephone visit. There would still be a requirement for at least 1 visit in person with the FP in the 12 months prior to submitting the CDM fee.

**Appendix 2:** **GPSC Telephone and Conferencing Incentive Revision Option Proposals**

1. **Virtual Patient Management Incentives**

Currently the GP Services Committee has 2 virtual care incentives for communicating with patients for Community FPs and 1 for GPs with Specialty Training, while the Specialist Services Committee has 2:

|  |  |
| --- | --- |
| Fee Description | Fee Value |
| G14076 – GP Attachment Patient Telephone Management (flat rate) | $15.00 |
| G14079 – GP Telephone/E-mail Follow-up Management Fee (flat rate) | $15.00 |
| G14023 – GP with Specialty Training Telephone Patient Management / Follow-up Fee - per 15 minutes or portion thereof | $20.00 |
| G10003 – Specialist Patient Management / Follow-up - per 15 minutes or portion thereof - telephone and video technology communication (including other forms of electronic verbal communication) | $24.05 |
| G10006 – Specialist Email Patient Management / Follow-up (flat rate) | $10.10 |

**G14079** is a telephone/email fee restricted to specific patient populations (those on whom a planning fee or COPD CDM have been successfully billed.) It allows a maximum of five 14079 billings per patient over the 18 months following the billing of the planning or COPD CDM.

**G14076** was developed as part of the Attachment suite of fees and is for use with any patient attached to an FP who submits G14070 (or their covering locum/colleague). G14076 may also be used for any patients under the care of a physician registered in a Maternity Network or an Unassigned Inpatient Network. It is limited to 1500/physician/calendar year.

In essence, both G14076 & G14079 are payable for telephone clinical advice to a patient (whether follow-up or acute). Both G14079 & G14076 can be delegated to College certified Allied Care Providers. Only G14079 allows medical advice from the physician to be relayed to the patient by an MOA, and only G14079 allows communication by e-mail.

14079 and 14076 are valued equally at $15.

Use of virtual technology for provision of medical care is one way to expand access to appropriate medical services.

The IWG proposes several revisions for consideration, to support increased capacity in family physician practices and align with similar incentives for specialist physicians by:

* 1. Developing a new GP Patient Communication fee for e-mail or text follow-up advice or relay of advice from the physician to patient by a College Certified AHP or an MOA. Proposed rate $10
	2. Delete **G14079**
	3. Increase the value of **G14076** to more appropriately reflect relativity to a base office visit. None of the GPSC telephone fees have increased in value since their inception, while MSP visit fees have increased with each PMA negotiated increase. Proposed rate $20. Initially keep same 1500 per physician per calendar year limit and restrict to FPs who are practicing in: BC PMH (use of portal either 14070 or other for PMH as decided by GPSC); Maternity Networks; Unassigned Inpatient Networks.
	4. Currently both the **G14023** for GP with specialty training patient telephone advice (and G10003 for specialist patient telephone advice) pay per 15 minutes or portion thereof. IWG recommends aligning the 14023 with the 14076 and paying both at a flat rate of $20.

The cost avoidance resulting from these patients not needing to be seen in-person would offset the increase of expenditure for a higher value for the telephone visit. Also, creating an email / text / telephone relay fee payable at a lower rate will result in additional cost savings that can be reinvested into the single Telephone visit fee. Since funding cannot be transferred from the MSP Available Amount to the GPSC to cover the cost of these virtual fees, it would be most appropriate to transfer them to the MSP AA where the cost avoidance/revenue neutrality would be generated. This will also allow these fees to receive any increases applied to similar MSP fees (eg. 13005, 00043) as a result of negotiated increases, to maintain relativity.

1. **Conferencing with Other Care Providers**

Currently GPSC has two sets of conferencing fees.

1. **G14077 Attachment Conferencing**

Access to G14077 is restricted to FPs who have submitted G14070/71 in the same calendar year. G14077 was introduced to simplify the earlier suite of 3 conferencing fees for use by GPs participating in Attachment into a single code with broader application. Despite the fixed end date for the A GP for Me project March 31, 2016, most of the Attachment codes developed to support that project were designed with the intention that they would continue as they were expansions of previous GPSC incentives.

No changes are proposed at this time.

For future consideration, G14077 currently supports team based care through conferencing with allied care providers who may be based within the PMH or who are part of the broader HA Primary Care Home (and other settings) as per FAQ 1.4 below.

***Q****.* ***Can G14077 be billed when a family physician conferences with Allied Care providers working within a practice, either employed by the physicians or employed by a Health Authority (or other agency) and embedded within the practice?***

*A. Conversations for brief advice or update about a patient, between GP and an allied care provider that is located in the GP office, are part of the normal medical office work flow and would not be eligible for G14077 as this does not meet the criteria. True case conferences that meet the requirements of G14077, whether scheduled or occurring due to an important change in patient status are not part of normal daily work flow, and would be eligible for G14077, regardless who the employer of the allied care provider is.  This is similar to the hospital or long term care based patients, where G14077 is not billable for conversations with allied care providers when on routine rounds but is billable for care conferences, discharge planning conferences, medication reviews (not when only for prescription renewals), etc.*

With implementation of the BC PMH, GPSC will need to determine if some kind of portal to fees will be necessary, whether **G14070** or a new one. This discussion is relevant to all GPSC incentive fees.

1. **G14015, G14016, G14017**

Since the introduction of G14077, utilisation of the initial suite of conferencing fees has been decreasing. The continued existence of this earlier suite of conferencing fees may be causing confusion, and evaluation on impact and projections is needed to determine if/when to discontinue them.

 As well, G14015, G14016 and G14017 allowed paperwork documentation to be included as part of the 15 min units of conferencing time, whereas 14077 does not. It is recommended that this be removed from these initial conferencing codes to align with G14077, to clearly state that this is payment for conferencing time.

Additionally, there is one MSP fee that is available for advice to allied care providers for patients “in community care” **13005**. The Society of General Practice should review this fee to determine the steps (if any) needed to align it to be complementary to the GPSC Conferencing fees in a way that makes these an integrated suite, in a similar way the proposed changes to telephone and e-mail/ technology fees would create a more comprehensive suite of codes.

Appendix 3: GPSC Fee Projections (Attached slides)