**TITLE:** GPSC Incentives Briefing Note 3/3: Update on incentive proposals in progress

**DATE:** April 24, 2017

**PREPARED FOR:** General Practice Services Committee

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**PURPOSE:**   *Discussion*   *Consultation*   *Information*  *Decision*

**ISSUE:**

This Briefing Note provides an update on new fees currently being contemplated by the Incentives Working Group (IWG). The IWG is discussing options to support panel assessment and maintenance, expand access to Complex Care planning fees to more patients with complexity based on functionality of patient rather than a particular diagnosis, change the CDM fees from disease-specific eligibility to broader patient chronic condition eligibility, and access to fees via a PMH portal and/or block payment. The IWG welcomes any feedback on these potential fees at this point.

**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.

**Proposals in Progress**

1) Fees to Support Panel Assessment and Maintenance

The IWG recognizes panel assessment and maintenance as foundational activities to the PMH. An understanding of one’s panel enables practices to plan and coordinate their services appropriately and to build a clinical team – whether in-practice or networked – according to their patients’ needs. The IWG, in consultation with PSP, is in the process of developing the parameters of incentives to support panel assessment and maintenance, understanding the operational resources that would be necessary to support physicians who would use the fees, and projecting the budget implications. The IWG is also planning activities to engage FPs as these new incentives are developed, which will likely begin at the GPSC Summit and continue during the summer.

2) Complex Care & CDM Simplification

**Context**

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. GPSC would need to consider a process for determining the criteria under which patients become eligible and could use:

* Patient demographic calculations (eg. ACG, RUB or other MoH process)
* Some of the health status groups from the Blue Matrix table to determine the targeted patient eligibility. Some of the categories which most logically fall under a revised complex patient support component are:
  + Frail in Care (residential care)
  + Cancer
  + High Complex Chronic Conditions (would need further definition/explanation)
  + Frail in the Community
  + Severe Disability
  + Mental Health and Substance Use (largely covered with G14043)

In 2003, the GP Services Committee launched its first Full Service Family Practice Condition Payment (CDM for Diabetes and HF). The program was enhanced in 2006 through an increased annual bonus amount for provision of clinical guidelines informed care for patients with diabetes and congestive heart failure (from $75 to $125 per person) and introduction of a $50 bonus payment for patients with hypertension management. This initiative was further expanded in 2009 to include a CDM incentive for COPD. The program payments recognize that additional work, beyond the office visit payments, of providing guideline informed care to patients over a year. The initial purpose of the condition based payments was to improve patient care as a result of significant care gaps that had been identified.

If the GPSC wishes to consider broadening the patient eligibility, this could be done by developing a tiered approach to payment for up to 3 co-morbidities eg. $100 for first condition, $75 for second condition and $50 for third condition for a maximum of $225 for patients with three or more co-morbidities. GPSC would need to determine a process to identify what would qualify as an eligible chronic condition.

To move away from a disease specific focus to a patient focused support of chronic illness care, the GPSC could consider expansion of the Chronic Condition Management incentives to support the shift to planned proactive care for any chronic condition that has a significant burden for patients. Eligibility could be determined by the number of chronic conditions a patient has to a maximum number, rather than by specific diseases. The Chronic Care incentives should be viewed as an overall support for the increased time, intensity and complexity of care required by patient with increasing numbers of co-morbidities. Eligible Chronic Conditions might be defined as those that meet the following criteria:

* Chronic persistent with potential to degenerate if not appropriately monitored and addressed
* Have the potential for multi-system impact
* Have an accepted guideline for management, either BC GPAC guideline or other internationally accepted guideline OR are known to be a cause of significant use of health care resources

**Complex Care/CDM Simplification Options**

Currently a patient with Diabetes, CHF and COPD qualifies for GPSC incentives of 3 X $125 for three CDMs plus $315 for the Complex Care fee for a total of $690. There are many patients with multiple complex comorbidities who do not qualify for any GPSC incentive fees. When considered as a package, there is significant overlap in the CDM and Complex Care Incentives. The CDM incentives are retrospective payment to recognize the time, intensity and complexity of care over the previous 12 months in support of guideline informed, planned proactive care for patients with chronic conditions. The Complex Care incentives are payment for a planning process and advance compensation for the time, intensity and complexity of managing these patients for the following year. For patients with any two of Diabetes, Heart Failure and COPD, there is in essence double coverage. The Complex Care Fee to plan for the coming year plus the CDM fees after 12 months of care, both designed to recognize time, intensity and complexity.

There is the potential to combine the Complex Care and CDM incentive funding to allow redistribution in a manner that supports incentive payments for managing the care of a larger group of complex patients. There are two potential options. One moves to a more blended holistic payment and one maintains a direct link between incentive and individual patient services. These options would be part of a longer term change; the IWG does not anticipate launching any of the following options, should they be approved by the GPSC, until sometime in 2018. When determining the timing of availability, consideration must be taken of the lessons learned from the past “double bump” effect when the initial 2 option Complex Care incentive was changed to the current single option Complex Care incentive.

1. ***Quarterly Payment for Complexity Option***

With the move to TBC in the PMH, GPSC could consider a quarterly payment calculated by looking at the previous year’s practice complexity and paid out in the subsequent year. Methods might include:

* Mini-profiles for each physician
* Blue Matrix
* Patient Demographic Calculation

If a BC PMH family physician accepts the quarterly payment for complexity, they would forgo billing any CDMs or Complex Care fees (including the Planning visit). GPSC could also consider whether the Mental Health and/or Palliative Care Planning visits would be included or excluded from this simplification. The GPSC could also consider making access to this payment model based on a commitment from the FP to the PMH model.

1. ***Chronic and Complex Patient Management Option***

Combining the changes to Complex Care planning and broadened CDM payments outlined in the sections above, GPSC could expand both the eligible patient populations and support team based care for those family physicians who do not wish to move to a quarterly payment for complexity option.

1. ***Chronic/Complex Condition Management:***

Utilization of guidelines to inform discussions of appropriate treatment options and monitoring of patient specific outcomes related to personalized treatment goals over a 12 month period. With additional conditions comes increasing complexity and time requirements, but this is not a linear association. A tiered approach based on the number of chronic conditions to a maximum is proposed. Discussion on whether this should be payment in advance of care or after 12 months of care would be needed.

Eligible patient populations would need to be determined as indicated above.

***ii. Complex Patient Planning Visits:***

For patients who are eligible for a Chronic/Complex Condition Management Incentive, the family physician would be able to provide a planning process as outlined in section 2 above.

Under this option, while payment for some patients would decrease, funding would be reallocated to other complex patients who currently do not qualify for any incentives For example, funding for patients with Diabetes/HF/COPD who currently qualify for $690 in incentive fees would decrease to $325 annually ($225 CDM + $100 Planning), while others with one, two or three conditions not currently covered would have $200, $275 and $325 respectively available.

Before moving in either/both of these directions, GPSC needs a cost analysis not only for budgeting purposes, but more importantly, to understand the business case and cost impact for FPs currently billing these fees in low, medium and high billing categories. The annual expenditures for the 4 CDM and 2 Complex Care Incentives is ~ $120 M combined.

**DECISIONS REQUIRED**

Does the GPSC want the IWG to stop pursuing any of the options above?

**IS THIS IS A FUNDING REQUEST?**

No  Yes

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

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

**ALIGNMENT WITH GPSC AND HEALTH SYSTEM PRIORITIES:**

**SUMMARY OF PREVIOUS GPSC CONSULTATION &/OR RECOMMENDATIONS**