Blended Capitation Model (BCM) – Frequently Asked Questions for Primary Care Physicians

1. **Who is eligible to participate in the BCM demonstration project?**

Any office-based comprehensive primary care clinic with a desire to advance the Patient's Medical Home is eligible for the BCM demonstration project. Ideally, all physicians within a prospective clinic will be interested in joining the model and practice exclusively in an office-based setting. However, clinics with at least 80% physician interest will be assessed for participation on a case-by-case basis. The goal of the BCM is advancement of the Patient's Medical Home and delivering a quality care experience to patients through improved access, continuity and comprehensive care. These driving principles are critical to success in the BCM.

2. **What is the demonstration project and why is a demonstration project being used?**

The BCM demonstration project commenced in November 2016, with the first clinic joining in 2017. The demonstration project is for early adopters of the BCM so that we can evaluate and learn about implementation. As an incentive, during this learning period, participants will be provided with quality improvement support from the AMA and receive a one-year negation-free period. The demonstration project allows the viability of the model to be explored in a live setting prior to full scale implementation. We are targeting for 10 clinics to participate in the model over the course of the demonstration period. The end of the demonstration period has yet to be determined.

3. **How has the Blended Capitation Model (BCM) changed since the first round of recruitment in 2017?**

When the first clinic went live on the BCM in 2017, we had an opportunity to learn from a real-world experience and make improvements. Several changes have been made to the BCM:

- Clinics will now be considered for the BCM demonstration project with less than 100% physician involvement, however a minimum of 80% is required.
- Both urban and rural clinics will now be considered for the BCM.
- Once clinics have transitioned to the BCM, they will now be able to bill two FFS claims per non-affiliated patient every two years.
- Virtual care codes and applicable out-of-office codes (z codes) have been added to the BCM basket of services.
- Recognizing that some negation will occur that is currently challenging to track, 7% of the total dollar value of negation will be forgiven.

4. **How will physicians be paid in this new model?**

The BCM blends a mix of patient-based (capitation) payments and volume-based payments (through FFS) to compensate clinics.

Clinics will receive a set capitation payment for each patient that they have formally affiliated. The capitation payments are calculated based on comprehensive health information that considers the patient's age, sex, and health profile group, which includes diagnostic codes, prescription drug utilization and overall system utilization. The capitation payment is intended to compensate physicians for any "in-basket" services provided. The clinic receives 85% of each patient's total capitation rate in equally divided payments 24 times over the year. Capitation

rates are based on CIHI Population Health Profile Groupings. There are over 9,560 different cohorts. Capitation rates are updated annually for affiliated patients. *(*Review *BCM Demonstration Project Model Elements* document for additional details.)

Physicians are eligible to receive the remaining 15% of the patient's total capitation rate through the provision of services. For in-basket health services, physicians will be paid the equivalent of 15% of the FFS rate, up to a maximum of 100% of the patient's capitation rate. All out-of-basket services will be paid at 100% of the FFS rate.

All other payments, such as the Business Cost Program, Rural Remote Northern Program, and any payments or in-kind services provided via PCNs will not change.

(Review *BCM BOS* document, that that outlines in-basket and out-of-basket services.)

5. How does compensation on BCM compare to FFS?

As part of the decision-making process before joining the BCM, clinics will be provided with the opportunity to participate in financial modelling to simulate BCM payments and negation based on a clinic's previous 3 years of billing. The financial modelling will help the clinic to understand how total compensation on BCM compares to FFS.

6. What is negation?

Negation occurs when a patient affiliated to a BCM clinic seeks in-basket services outside that clinic. When a patient receives an in-basket service outside the BCM clinic, the clinic is financially negated for the cost of that service. The negation rate is 100% of the FFS cost of the in-basket services provided outside the clinic. The clinic cannot be negated more than 85% of the capitation rate for each patient.

Negation can be mitigated by implementing practice change, for example:

- Having discussions with patients when they are affiliated and asking patients to call the clinic first for any health care needs;
- Ensuring access for patients to get an appointment when they need; and
- Using alternative modes of care (e.g., virtual or phone visits, optimizing an interdisciplinary team).

Not all negation is avoidable. Because of this, 7% of the total dollar value of negation will be forgiven.

7. What is included in the basket of services?

The basket of services has been developed to reflect the typical medical services delivered by a family physician in an office-based setting. Any health service included as part of the basket of services is referred to as an "in-basket service". These services will be used when determining blended capitation payment along with other factors as described further in question 4.

The basket of services is regularly reviewed and updated. (Review *BCM BOS* document, that that outlines in-basket and out-of-basket services.)

8. What does the physician-patient affiliation process entail?

To formally affiliate a patient to a BCM clinic, both the physician and patient will sign a form agreeing to a physician-patient relationship and its associated expectations and benefits. Completed forms will be collected by clinics, who will then submit the corresponding patient information electronically to Alberta Health through the Central Patient Attachment Registry (CPAR).

Patients not eligible for AHCIP are not eligible for affiliation to the BCM. Payment for services provided to these patients and uninsured services does not change; these patients can remain on your panel.

Patients can also be de-affiliated. There are many reasons a patient may be de-affiliated automatically, such as if they are admitted to long-term care. A patient may also be manually de-affiliated, for example, at the patient's request.

9. What about patients who don't want to affiliate or are transient?

Physicians can bill FFS for up to two in-basket claims with each unaffiliated patient over a two-year period without formally committing to the relationship by affiliation. Any subsequent FFS claims for an unaffiliated patient will not be paid.

10. What is required of me (and my clinic) and what supports are available?

Clinics on the BCM will likely see increased need for administrative work, for example, reviewing monthly negation reports. There will initially be an increased workload obtaining signed affiliation forms.

From the decision to join BCM to a clinic "going live" can take 5-6 months of preparation before the first year of support and negation-free period begins. Recommended preparatory work can include reviewing the business structure of the clinic and ensuring adequate documentation of policies. Clinics are strongly encouraged to amend or create a practice agreement that reflects business processes aligned to the BCM and the Patient's Medical Home.

During the demonstration project, clinics will be provided with facilitation support for process redesign (administrative and clinical) via the AMA. The level of support will vary based on clinic needs and experience with quality improvement. The clinic relationship with the PCN does not change and clinics are welcome to receive support and interdisciplinary team members from their PCN.

11. Can I continue to operate a walk-in clinic? Can I operate a specialist interest clinic? (e.g. women's health, pediatric, contraceptive (vasectomy, IUD), weight loss)

Episodic care for patients who are not affiliated under the BCM is not aligned with the principles of the BCM in keeping with the Patient's Medical Home and continuity. A clinic is only allowed 2 in-basket services for non-affiliated patients per 2-year period.

Depending on context, it may be possible to operate a specialty interest clinic within or outside the BCM. This would be explored on a case-by-case basis. Factors to consider include whether the services provided are in-basket or out-of-basket.

12. Can I work at another clinic?

Classification: Protected A

Yes, you are free to work elsewhere under FFS models.

13. Can I work part-time?

Yes, part-time and full-time physicians can work within the BCM.

14. I've heard of other capitation models or alternatives to FFS. Are they available too?

There are two other models of capitation currently operating in Alberta. Currently AH is not offering these models to other clinics. A clinic may choose to leave BCM and join any other available model, should any become available. Clinics may also return to FFS. Participation in the BCM is entirely voluntary.

Other clinical ARPs include sessional and annualized models.

15. What is the ideal panel size for BCM?

The number of patients affiliated will vary by clinic. The ideal panel size depends on your ability to provide access to all patients on your panel in a timely manner. Support offered from the AMA can help you to determine your demand and supply to begin to understand what your ideal panel size is as a clinic and as an individual physician.

16. Are there Information Technology requirements for physicians who transition to the BCM?

Yes. Physicians will be given access to the program 'APP Online' in order to view and generate reports related to payments and negations. In order to track affiliation of patients, they will also utilize the Centralized Patient Attachment Registry (CPAR). Participating clinics will also be required to use an electronic medical record (EMR). Clinics will receive support from Alberta Health prior to implementation to learn how to use APP Online and CPAR.

Through APP Online, participating clinics will have access to a Capitation Payment Summary, which will list all patients affiliated to the clinic and their associated capitation payment, any FFS payments, and total negation. Clinics will also have access to a Formal Negation Report, which will show all services that affiliated patients have received outside of their home clinic for each pay period. The Formal Negation Report will be accessible during the negation free period in the first year after joining the BCM.

17. Where can I get more information on the Blended Capitation Model and/or express my clinics desire to participate?

Clinics seeking more information or that are interested in joining the model as a demonstration project are invited to contact the BCM Implementation Team directly (contact info below) to express their interest in participating.

Please e-mail Alyssa Scott at alyssa.scott@gov.ab.ca or Christine deMontigny at Christine.deMontigny@albertadoctors.org