Vancouver
Division of Family Practice
A GPSC initiative

Exploring Value Based Payment for Family Physicians in Vancouver

Background

Around the globe, healthcare systems are being 'reformed' around a set of common, high-level goals first described as the Triple Aim. Widely accepted as the key attributes of quality healthcare, these aims include: lowering per capita healthcare costs, enhancing the patient experience (quality and satisfaction with care), and improving population health. Enhancing the healthcare providers' experience has recently been proposed as a fourth aim and highlights an important aspect of value based payment (VBP).

Primary care reform in Canada goes back about 17 years. From 2000 through 2006, the Federal government supported provinces and territories to redesign the delivery of primary healthcare through the Primary Care Transition Fund. Efforts were operationalized differently across the country with regards to how interdisciplinary primary care teams were designed and implemented. Alberta and Ontario took top-down approaches and introduced system-wide policy frameworks to which primary care providers could voluntarily adhere to. Financial rewards for physicians were built into payment models and used to incentivize participation. Over this period, the government of B.C. experimented with different frameworks such as patient-doctor dyads, and implemented financial incentives for primary care physicians (i.e. guideline-informed complex care) but did not settle on a top-down policy direction. Approximately 14 projects that implemented team-based primary care using VBP models have been funded in B.C., however none of these projects have been formally evaluated.

The ways in which Canadian provinces fund healthcare, including physician remuneration, is a critical issue facing decision-makers. International literature around this topic suggests that aligning healthcare system goals with funding methods and payment models through use of financial incentives makes sense, however process literature on the design and implementation of funding models and physician payment in support of interdisciplinary team-based care is limited.

In 2011, the College of Family Physicians of Canada (CFPC) presented the Patient's Medical Home (PMH) as a vision for the future of family practice in Canada, and the government of B.C. is now moving forward with plans to initiate team-based primary care province-wide. Using the PMH model as a framework, the Vancouver Divisions of Family Practice (VDoFP) is currently exploring how VBP might incentivize physicians to engage in transformation efforts that align with the CFPC vision and the B.C. government's goals for team-based primary care towards achieving the Triple Aim.

Defining Value Based Payment

The literature on VBP is immature and 'messy' to navigate and distill. Part of this is a problem with language. There is no common lexicon for this field and basic concepts such as capitation have been tweaked and rebranded by government payers, making it difficult to group ideas and available evidence. Canada has not established a clear research agenda for evaluating funding and payment models, resulting in a fragmented evidence base and challenges in sharing information across jurisdictions. Published systematic reviews criticize the quality of studies on payment models, citing weak study designs and methodological flaws when statistical modelling is used in the absence of 'real' patient data.

A proposed working definition for VBP that has been adapted from a variety of sources:

Value Based Payment refers to a broad set of performance-based payment strategies that link financial incentives to health care providers' performance on a set of defined measures to achieve better value. Value is defined as the outcomes achieved divided by the cost or resources used to generate those outcomes. All outcomes are presumed to advance the Triple Aim goals of delivering high quality healthcare: better care, better health, lower cost. VBP benefits the patient, the healthcare provider and the payer.

Purpose of this Paper

This paper has been developed as a discussion tool for the VDoFP as they begin to explore VBP as a potential incentive for transforming primary care practice and stimulating uptake of the PMH model. A review of published literature provides a baseline understanding of major healthcare funding models and the high-level drivers for payment reform. Benefits and limitations of each is discussed. Physician payment types are reviewed with a focus on the strengths and weaknesses of each, and considerations for implementation (e.g. resources required). Summarized, the content provides a framework to support discussion centered on the PMH model of care in Vancouver.

Healthcare Funding Models

To consider opportunities for VBP, it is necessary to understand how healthcare is funded in Canada and what impact funding models have on the cost and quality of healthcare. *How* healthcare is paid for can have a strong influence on the behaviors of providers, including physicians. Funding models have the potential to cause fragmentation or encourage integration of care delivery within health systems. Despite the stated desire for greater integration, healthcare has been traditionally organized and funded in silos (i.e. primary care, acute care, home and community-based care, mental health and public health services) resulting in 'dis-integration' between sectors with regards to financial flows, performance measurement systems, organizational structures and governance arrangements.

Governments considering large scale change to funding models need to consider that:

- The nature of payment reform will differ depending on the type of system that is being replaced
- Efforts to integrate physician payment with those for other providers may require changes to legislation and regulation
- 'Big bang' approaches don't work; overlaying new models on existing ones to start with is a viable option
- You can only pay for what you can measure, and many provinces lack comprehensive data around sectors such as post-acute and community-based care

The following section describes the major healthcare funding models

Population-Based Funding

Population-based funding (PBF) is a method of allocating funds for healthcare to regions. PBF uses data about a population's health status and healthcare utilization to project a region's future healthcare expenditures. It is an equitable approach, especially in countries like Canada where a single funder (provincial government) is responsible for the entirety of the population's health, because it is based on the characteristics of the region's residents.

PBF strengthens regional autonomy and allows for flexibility around perceived needs, although its effectiveness relies on the accurate measurement of a population's health or healthcare needs using historical utilization data. This data does not include patients who *could* benefit from health services (under-utilization of care) or those who receive care but derive no benefit (over-utilization of care). Funding calculations often use low socio-economic status as in indicator of need, based on the thinking that poor people tend to be unhealthier, however this relationship is more complex. PBF was introduced in B.C. in 2002 and was used to allocate funds to Health Authorities for acute, home and residential care. The B.C. government recently went back to funding through global budgets.

Global Budgets

Global budgets are the most common funding method for healthcare in Canada. Under this method, a fixed amount of funding is distributed to a healthcare provider, such as a Health Authority, who is then responsible for delivering services to the regions' residents for a fixed period. A strength of global budgets is that they effectively control spending through use of a 'cap'. The downside is that providers may restrict access to services resulting in waitlists, and global budgets provide little incentive to improve efficiency, invest in quality, or integrate services with providers across the continuum of a patient's care. Canada is unusual in its extensive use of global budgets. Most countries have moved to activity-based funding (ABF),

and have used the financial incentives of ABF to improve access to care while minimizing the risks to quality and safety.

A drawback of global budgets is the lack of incentive for hospitals to integrate services with post-acute care providers. This is evident in the Canadian healthcare system where one in eight beds is occupied by a patient awaiting discharge (or alternate level of care), and the transition between hospital and community can pose a risk to patients. Resulting system costs are higher, clinical outcomes are compromised, and access is reduced for those waiting. While physicians have influence on how healthcare systems allocate resources, they are not paid out of global budgets, nor do they share accountability for spending.

Activity-Based Funding

ABF refers to a method of funding healthcare providers based on the kind of care delivered, and the patient's complexity of care. It is also referred to as 'volume-based funding', 'service-based funding', 'case-mix funding', or 'payment by results'. Unlike global budgets where patients represent costs to the system, under ABF patients are a source of revenue. ABF relies on patient information and what occurs during a hospitalization to describe and quantify hospital outputs. Classification systems have been developed to inform ABF, the most popular being 'diagnosis related groups' (DRGs). In Canada, the Canadian Institute for Health Information (CIHI) maintains a classification system known as CMG+. ABF can create transparency in funding and incentives for increasing productivity and efficiency, and is often associated with increased access to hospital care and reduced wait time for acute care services. The downside of ABF is that with increased 'activity', comes increased costs. ABF also requires an intensity of information and ongoing data collection for its support. The possibility to 'game' revenues by manipulating data is a concern, and Canadian provinces have yet to develop policies to monitor and enforce clinical data standards to minimize these risks.

Despite it being best-suited for acute services, ABF is being adapted in several countries to fund non-acute care in areas such as long-term care, mental health, continuing care, inpatient rehabilitation, and ambulatory care. These efforts are challenging, as there are no well-established patient classification systems like DRGs, and accurate patient-level data from these areas upon which to build classification systems is lacking.

Pay-for-Performance

There is no accepted definition for pay-for-performance (P4P), which is also referred to as paying for results or results-based financing. Where ABF pays based on volume, P4P pays for achieving pre-specified objectives such as thresholds of quality or safety.

P4P is most commonly used as a method to link physician activity to remuneration, and can be paired with any payment model. By 2012, as many as 19 Organization for Economic Cooperation and Development (OECD) countries were using P4P programs to improve the

quality of primary, specialty and hospital care. In primary care, most bonuses are for preventative care and management of chronic diseases. The Quality Outcome Framework (QOF) in the U.K., established in 2004, is the largest P4P program in the world and rewards general practitioners for how well they care for patients.

P4P methods appear to be most effective when they target preventative and public health services such as cancer screening, vaccination rates, measuring and treating blood pressure, and counseling patients to quit smoking or improve their diet. Implementing P4P can create unwanted incentives, like 'teaching-to-the-test', which refers to the tendency to concentrate on the processes which are targeted, and ignoring or skimping on processes that are not.

Like ABF, P4P programs place significant demands on healthcare information systems, and can require datasets not routinely collected in Canada. Despite widespread adoption of P4P initiatives, evaluations reveal mixed impacts or weak results. Increases in quality tend to be modest, incremental, or temporary and there is little evidence showing positive patient outcomes from these programs.

Integrated Funding Models

Integrated funding models share a theme of aligning common financial incentives across groups of previously disconnected providers (Health Authorities, family physicians, specialist care), with the goal of increasing integration, and decreasing fragmentation of care. Bundled payments and population-based integrated payments are examples of this type of funding.

Bundled payments are a possible remuneration method for episodes of care. A 'bundle' is defined as the set of services or treatments provided to a patient for an episode of care. A bundle of care includes all aspects of a patients' care across providers and settings over a fixed period of time. An example of a bundle of care is a knee replacement surgery.

For bundled payments to create effective incentives accurate, linkable and timely data must be collected across all healthcare settings including hospitals, post-acute care, physicians, and emergency departments. Much like ABF and P4P, clinical utilization and cost data need to be reliable and consistently measured and reported. While other funding models can operate in isolation from physician payment methods, physicians play a critical role in bundled payments. Physicians' decisions influence hospital use and post-discharge care, however physicians are generally funded separately from the hospitals on a fee-for-service basis. Ensuring physician engagement is key to the success of bundled payments, as well having a clinical governance system that considers both provider and payer perspectives.

The strength of bundled payments is that they create financial incentives for the coordination and integration of providers across different settings. Bundled payments hold linked providers accountable to their peers (within the bundle) for the cost of care they provide during an episode of care. Other potential advantages of this type of funding include reducing the risk

of ‘cost shifting’ between sectors and holding providers responsible for the consequences of fragmented care, rather than the system at large.

Conditions or procedures that are best suited for bundled payments are characterized by clear clinical pathways. Deciding which provider in an integrated health system should act as the ‘paymaster’ is one of the greatest challenges.

Population-based integrated payments (PBP) involve sharing payments among groups of multiple providers who assume accountability for costs and quality in managing a population of patients. Examples include Accountable Care Organizations in the U.S. and the Gesundes Kinzigtal model in Germany. These tend to be primary care-driven with a focus on case-managing complex patients and reducing avoidable hospitalizations. PBP is discussed in greater detail under Fundholding Models.

Physician Payment Models

While the Canadian healthcare system has had a long-standing reliance on the fee-for-service (FFS) physician payment model, there is consensus in the literature that there is a need for payment reform as an integral part of transforming primary care.

Physician remuneration across Canada is a rapidly changing landscape. The 2013 National Physician Survey (NPS) results provide the most recent picture of family physician compensation. FFS remains the most prevalent model, although pure FFS has dropped to 32% from 52% in 2004. In physicians reporting earnings from blended income models, at least 42% came from FFS, 17% from sessional/per diem/hourly and 13% from capitation. Younger physicians tend to prefer non-FFS, with 70% of newly practising physicians in B.C. preferring alternative payment including salaried, capitation or blended models.

There are two main physician compensation models in B.C., FFS and the alternative payments program (APP). APP is used to describe the funding of physician services other than the FFS method. Alternatives to FFS funding are being sought by physicians and healthcare providers, and budget for alternative funding has steadily increased over the last decade and now represents twenty per cent of the overall available amount for physician services. Physicians can also receive funding through rural practice programs, which focus on recruiting and retaining physicians in rural practice, and through the Medical On-Call Availability Program, which compensates physicians for being on call. Physicians in B.C. are remunerated under one main negotiated agreement, the Physician Master Agreement, which covers the relationship and economic arrangements between the Government of B.C. and the Doctors of BC.

The following section describes the major physician payment models

Fee-for-Service

FFS is a retrospective payment system that covers costs incurred by the physician plus a margin for each service they provide. Payers (i.e. provinces) create a schedule of benefits that outlines the fees paid for each service or procedure that the physician provides.

As a system that rewards volume, there is little incentive for physicians to consider costs or clinical outcomes when treating their patients and the model has been labeled a 'perverse incentive'. FFS physicians provide more consultations and diagnostic testing than their non-FFS counterparts. By rewarding volume over value (appropriate treatments and desired outcomes), the FFS system may be punishing effective use of preventative care, specialist/hospital care, and effective chronic disease management. There is concern about the phenomenon of 'supplier-induced demand' (SID) which occurs due to an imbalance of power and knowledge in the physician-patient relationship. FFS is associated with more hours per week worked in direct patient care than alternative payment models, and higher levels of professional satisfaction among physicians working in capitation and salary-based settings.

Enhanced Fee-for-Service

The FFS model lends itself to offering incentives and premiums on top of the existing fee schedule. These enhancements may be offered for complex and chronic disease management, or as block payments to complement the FFS in rural areas, or for physicians who are providing care to special-needs populations. Incentives and premiums can be used to encourage desired reform to primary care practice. Enhanced FFS can also target care outcomes through performance-based incentives, including preventative care bonuses (pap smears, mammograms, childhood immunizations, flu shots), special payments (hospital services, palliative care, prenatal care, home visits), chronic disease management (diabetes, congestive heart failure) and incentives to enroll patients who have no regular family doctor.

From 2002 through 2010, B.C.'s primary care reform efforts were based on promoting 'full-service family practice' through incentive payments (following B.C. Clinical Guidelines for diabetes, CHF, COPD and hypertension) and other practice support programs for physicians (maternity care, complex care, mental health planning, cardiovascular prevention). At the heart of this initiative, was the idea that the doctor-patient dyad is central to the provision of primary care.

Capitation

Capitation is used to describe a prospective payment system, in which there are many variations. Under capitation and 'next generation' capitation models, physicians are paid an

upfront fixed amount (possibly risk adjusted for age, sex, morbidity or other modifiers) for each patient in their practice. In return for this fixed amount, the physician is contractually obligated to provide primary care to the patient for a given period without additional reimbursements. More volume does not translate into more income with each additional visit or treatment being costly to the physician in time and effort. Capitation eliminates the incentive to encourage additional care. Tying the physician's income to their patients' future use of care may provide financial incentive for the physician to maintain their patients' health over long-term relationships.

Capitation can encourage physicians to supply services such as phone or email consultations, which are not traditionally reimbursed within the FFS model. Patient rostering can positively impact a primary care practice by allowing physicians to define their panel size, organize appointment scheduling, track health indicators and outcomes, and increase team member and patient satisfaction. Rostering increases the likelihood for continuity of care, enables timely appointments, and links the patient formally to their family doctor and team.

The capitation model has the potential to negatively impact quality of care in several ways. It may create incentive for physicians to select patients who require little future care ('cherry picking') making it difficult for older or chronically ill patients to find care. It may also lead to excessive use of specialty and hospital care because capitation payments generally do not cover this type of care. There is risk of under-provision of care, where physicians under-report a patient's illness to them or choose not to disclose all possible treatments to create a smaller demand for care. This is a concern in Canada where physicians face very little competition, and patients who are not satisfied may find it difficult or impossible to find care elsewhere.

From a system perspective, capitation can provide stable and predictable expenses, which is advantageous for insurers and payers. On the downside, this also means that if costs rise due to external factors such as inflation, they might be shifted onto physicians whose overhead expenses are estimated to be as much as 28-36% of their gross income.

The Fundholding Model

The fundholding system which started in the U.K., is an inclusive prospective payment model like capitation, except that physicians in a fundholding system are responsible for almost all the patient's medical consumption including prescription medications, specialty care and hospitalizations. The fundholding system provides the right incentives regarding prevention and chronic disease management because keeping one's patients healthy leads to less future care and expenses and greater revenue opportunities. Fundholding models are generally targeted to teams rather than individual physicians. As with capitation, this model may be financially risky for physicians/teams if they face income variations outside of their control. Selection of low-risk patients is likely to be even more problematic than in capitation models.

In Ontario, Patient Care Groups (PCGs) are a newer (2015) example of population-based fundholding organizations that are accountable to the ministry through the Local Health Integration Networks (LIHNs). PCGs take many forms (i.e. Family Health Teams, Hospitals, Community Health Centers). While PCGs are reflected in the primary care structure, there are many innovative features:

- Primary care providers, along with the local Public Health Unit and municipal services, are responsible for the health of the population within their catchment area
- The model ensures clear lines of accountability between primary care providers and patients, and between primary care providers and the broader system
- The model ensures universal access to primary care; there are no unattached patients
- The model aligns with the goal of equity of access to inter-professional resources
- The model leverages existing organizations and capabilities to provide better integrated care, both horizontally (coordination between primary health care practice settings) and vertically (coordination between primary health care and other parts of the system)

In the United States, Accountable Care Organizations (ACOs) are fundholding models. ACOs are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated, high quality care to their Medicare patients. The goal of this coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. ACOs share in savings from the Medicare program. Medicare offers financial incentives to healthcare providers for becoming an ACO (i.e. Medicare Shared Savings Program, Advance Payment ACO Model). In Obamacare, each ACO manages the healthcare needs of a minimum of 5,000 Medicare beneficiaries for at least three years. About 6 million Medicare beneficiaries are in an ACO, and combined with the private sector at least 744 organizations have become ACOs since 2011. In 2015, an estimated 23.5 million Americans were being served by an ACO.

Mixed Payment Models

Mixed payment models can be useful to compensate for the negative aspects of FFS and capitation models (over/under provision of care) and find a balance between the observable types of care, such as diagnostic tests and treatments, and un-observable types of care including physician time and effort. These models include a prospective component (an upfront capitation-like payment or salary) and a retrospective component (a marginal reimbursement like a FFS payment). Patients value both observable and un-observable types of care, and mixed-payments will simultaneously provide an incentive for quality and cost control. Mixed payment models compensate valued services that are not reimbursed by FFS such as research, administrative duties, and teaching by providing an up-front payment to physicians independent of the number of patients that they see.

Salary

In a salary model, physicians receive a wage like other workers in the formal economy. The salaries are based on units of time, and paid in regular installments. Salaried physicians often have a contract that stipulates practice responsibilities and privileges, in the case of hospital medicine. Salaries can be a useful tool for recruiting physicians to rural and remote areas and offer a stable, predictable and sufficient income for those working within a low population density. Salaried physicians often receive additional benefits (extended health, paid vacation, relocation costs) as part of their compensation. Salary reimbursement is associated with the lowest use of diagnostic tests and referrals compared with FFS and capitation, as well as lower number of patient visits, longer consultations and more preventative care. It is not clear whether the reduction in tests and procedures affects patient health outcomes. Salaries have been criticized for negatively impacting productivity, and motivating physicians to spend more time with each patient. The concern is that this model's costs do not lead to a greater level of service or quality of care.

Of ten leading health systems in the USA in 2014, five pay their physicians using productivity-independent salaries, and five use productivity-adjusted salaries. Within these systems, performance-based pay is more prevalent in primary care than in subspecialties. The most consistently identified performance domains are quality, service, productivity and citizenship, each containing several metrics, so that physicians may be responsible for 10-20 metrics during any given measurement period. Most organizations have less than 10% of the physician's total compensation at risk. Payment models with many metrics, and very little compensation at risk for each metric, may not provide enough incentive to achieve goals. Some organizations choose to focus on two or three metrics in a measurement period to avoid diluting incentives. Often, organizational culture and non-financial incentives such as public reporting and recognition can be as powerful a driver as performance-based compensation. Payment models tied more to performance, and less to productivity may free physicians from traditional 'volume' constraints and empower them to be more engaged change agents.

Though few primary care physicians in B.C. are paid by salary, there are examples of self-organized physician groups who incorporate in a business partnership and pool their FFS revenues and other financial incentives and share overhead expenses. Each member of the corporation is payed an agreed upon salary from the net revenues of the group.

Sessional Contracts

Sessional contracts can provide flexibility for managing complex or time-consuming patient care, or for short-term relief of physician supply issues in rural and underserved areas.

Private

In addition to public health care providers such as primary care doctors and hospitals, many private clinics offering specialized services operate in Canada. Under federal law, private clinics are not legally allowed to provide services covered by the Canada Health Act. Regardless of this legal issue, many do offer such services. Private enterprises are freer to experiment with business and payment models and are more innovative. Evaluations of these initiatives are proprietary and therefore information about payment models is rarely available.

The Copeman Healthcare Centre which opened in 2005, is an example of a private for-profit business that has primary care facilities in Vancouver, West Vancouver, Calgary, and Edmonton. The Centre describes itself as "Canada's first team-based, multi-disciplinary centre for primary healthcare, focusing on the diagnosis, treatment and management of disease while using the same medical experts to develop advanced programs of prevention." Though Copeman is a private clinic, doctors working there bill provincial health plans through FFS arrangements, and the company maintains that the fees paid by patients are strictly for non-insured health services. This has been highly contested by health ministries over the past 12 years, but not legally challenged. In the Life Plus Program, patients pay a program cost of around $4000/year to receive an annual health prevention screening and 12 months of personalized, 'unhurried', prevention-focused primary healthcare. Patients can purchase individual services from the centres. In addition to a primary care physician, patients have 'no wait' access to an extensive network of physician specialists and other allied health providers such as dietitians, kinesiologist and clinical psychologists. Communication between providers is technology-enabled, and patients have access to education programs such as the Carebook Health Management System.

Summary

Despite limited and relatively non-generalizable evidence for implementing VBP, the trend towards integrated population-based funding and value based physician payment models that align with increased integration seems inevitable. At the Division level, VBP should be explored as an incentive for physicians to adopt the PMH model of care.

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