SASKATCHEWAN MEDICAL ASSOCIATION

Transitional Payment Model

Information Booklet

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TPM Background

The Transitional Payment Model (TPM) described in this booklet is a steppingstone **toward a longer-term vision to transform primary care in Saskatchewan**. It is a cornerstone achievement of the four-year contract recently ratified between the Saskatchewan Medical Association (SMA) and the Ministry of Health.

The TPM is a voluntary transitional model developed to stabilize family medicine and address pressing challenges for family physicians, as the infrastructure and systems are built for a full blended capitation model.

The TPM helps family physicians in Saskatchewan remain financially competitive, lays the groundwork for a culture shift to a Patient's Medical Home (PMH) framework and integration with Health Networks, provides **building blocks for family physician-led, team-based care**, and creates an attractive environment for retaining family physicians and new graduates in Saskatchewan.

TPM recognizes and supports the delivery of longitudinal community-based family medicine by:

- Promoting longitudinal care within family medicine.
- Acknowledging the work required to provide longitudinal care to a patient panel.
- Increasing patient access to primary care.

The origins of the TPM can be traced to the previous agreement with the government, which covered the years 2017-22. The SMA and the Ministry agreed to form a joint Primary Care Compensation Working Group (PCCWG) to **recommend future compensation model(s) that better support community-based family physicians.**

The PCCWG analysis found that family physicians working in conjunction with and leading other primary health care professionals - where resources are aligned, and continuous improvement is embedded in the team's culture - is essential to deliver patient-centred integrated team-based care. This vision is transformational. The PCCWG also examined compensation models in other provinces to identify the best approaches to attract and retain family physicians.

TPM Background

The PCCWG chose the best ideas from other provinces and built on Saskatchewan's strengths. It recommended a longer-term vision of a Saskatchewan-made blended capitation model with mutual accountabilities. This vision will take time to advance. At the same time, the PCCWG clearly heard from physicians about the urgency for immediate support for family physicians so that they could continue to provide longitudinal family medicine to Saskatchewan patients.

As a result, the PCCWG recommended a transitional payment model, which you will read about in this booklet. The TPM was adopted in the new agreement, which covers 2022-26.

The TPM represents a significant turning point for family practice in Saskatchewan.

The payment model compensates Family Physicians for the following:

Fee-for-service (FFS) payments: All usual FFS payments.

Payment for longitudinal care and patient panel: A maximum $144,000 capitation payment to fee-for-service family physicians who provide longitudinal care for a patient panel, including indirect care, screening and prevention activities, chronic disease management and comprehensive care.

Accountabilities: There are TPM accountabilities for family physicians to build their Patient's Medical Homes, including working in physician groups with an identified physician lead (paid role), understanding the physician-patient relationship, participating in learning sessions on the PMH and Health Networks, and monitoring and measuring progress over the next two years.

TPM Highlights

Eligibility

To be eligible for the program, FFS family physicians must:

- ☐ Be licensed to practice and currently reside in Saskatchewan.
- ☐ Hold Saskatchewan Health Authority (SHA) appointments/privileges.
- ☐ Practice longitudinal family medicine as the majority of their practice in a Saskatchewan community.
- ☐ Commit to being the Most Responsible Physician (MRP) to a panel of patients and document patient understanding of the relationship (process in development).
- ☐ Commit to providing chronic disease management including submitting CDM-QIP flow sheets.
- ☐ Provide comprehensive care and on-call services.
- ☐ Participate as part of a group (a clinic group or multiple clinic groups for solo physicians) to ensure adequate service and call coverage. The SMA and the SHA are available to help the formation of physician groups. Please email pmh@sma.sk.ca for more information.
- ☐ Assign a family physician as the physician group lead (paid role).

The Transitional Payment Model is available to family physicians as of April 1, 2024.

Registration

Registration is now open and voluntary. You only need to apply once and can choose to withdraw at any time without penalty. Payments are quarterly and reconciled annually. The TPM will have a joint review by the SMA and the Ministry by March 31, 2026.

If your registration is received within 60 days from the start of the quarter, you will be paid retroactively for that full quarter. If registration occurs after 60 days into the quarter, your payment calculation will begin on the date of registration. Please see the following examples:

- **Q1 (April-June):** there is an extended application deadline of June 21 to receive retroactive payments to the start of the quarter, April 1, 2024.
- **Q2 (July-September):** if you apply within 60 days (August 30th) the TPM start date is retroactive to the start of the quarter, July 1, 2024.

The first TPM payment calculations will use utilization data based on date of payment, from fiscal years 2021-22, 2022-23 and 2023-24. Subsequent semi-annual calculations (April & October) will follow the same method, using data from the previous three years. General fee increases for family practice for April 1, 2025, will be applied to TPM (i.e., $144,000 will increase at the same rate as the FP increase for April 1, 2025).

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TPM Components

To recognize and value the unique relationship between family physicians and their patients, and the longitudinal work resulting from this relationship, a new Transitional Payment Model (TPM) was designed. **The model pays FFS family physicians for volume of service, plus an additional capitation payment for longitudinal care and panel size.**

TPM = Usual FFS payment + capitation payment (longitudinal care & patient panel)

Fee-For-Service Payments: Paid at current FFS rates, with no caps on service volume.

Capitation Payment is up to $144,000 per year in new funding and will be provided to FFS family physicians who enroll in the TPM. The formula has two-parts, as outlined below:

Longitudinal Care: To recognize family physician longitudinal work, patient contacts will be used as a proxy. This is represented in each patient encounter where a family physician provides primary care (in-person or via virtual care). The encounter is considered one contact based on date regardless of the number of services provided during the encounter (contact count is limited to one contact per patient per day). **The 6,500 contacts threshold is NOT associated with any kind of target number of contacts.** Although the contact ratio is calculated using a threshold of 6,500 contacts per year, there is no limit on the number of patient contacts a participating physician may have. Physician billing data is used to determine the number of patient contacts. Contacts are calculated quarterly and reconciled at the end of the year (Fiscal: April 1- March 31).

Longitudinal Care | **Patient Contact Ratio** = $\frac{\text{\# Contacts}}{\text{Contacts Threshold (6,500)}}$

Patient Panel: Physicians in the TPM will receive compensation to provide longitudinal care to a panel of patients assigned to them. Panel Size uses the 4-cut Method as a proxy to measure the number of matched patients. This is not our long-term solution. The 4-cut matching methodology uses a three-year data analysis period to match Saskatchewan patients to a family physician where most of their primary care services were billed to the Medical Services Branch (MSB) and is calculated semi-annually (April and October) (see Figure 2). **The 1,600 panel size threshold is NOT associated with any kind of target panel size.** Although this ratio uses a metric of 1,600 matched panel patients, there is no limit on the number of matched/empaneled patients a physician may have (the minimum eligible panel size for an individual physician is 250).

Patient Panel | **Patient Panel Ratio** = $\frac{\text{\# Matched Patients}}{\text{Panel Size Threshold (1,600)}}$

TPM Payment Details

Patient Matching: For the TPM Model, patients are matched to only one provider using the 4-cut method:

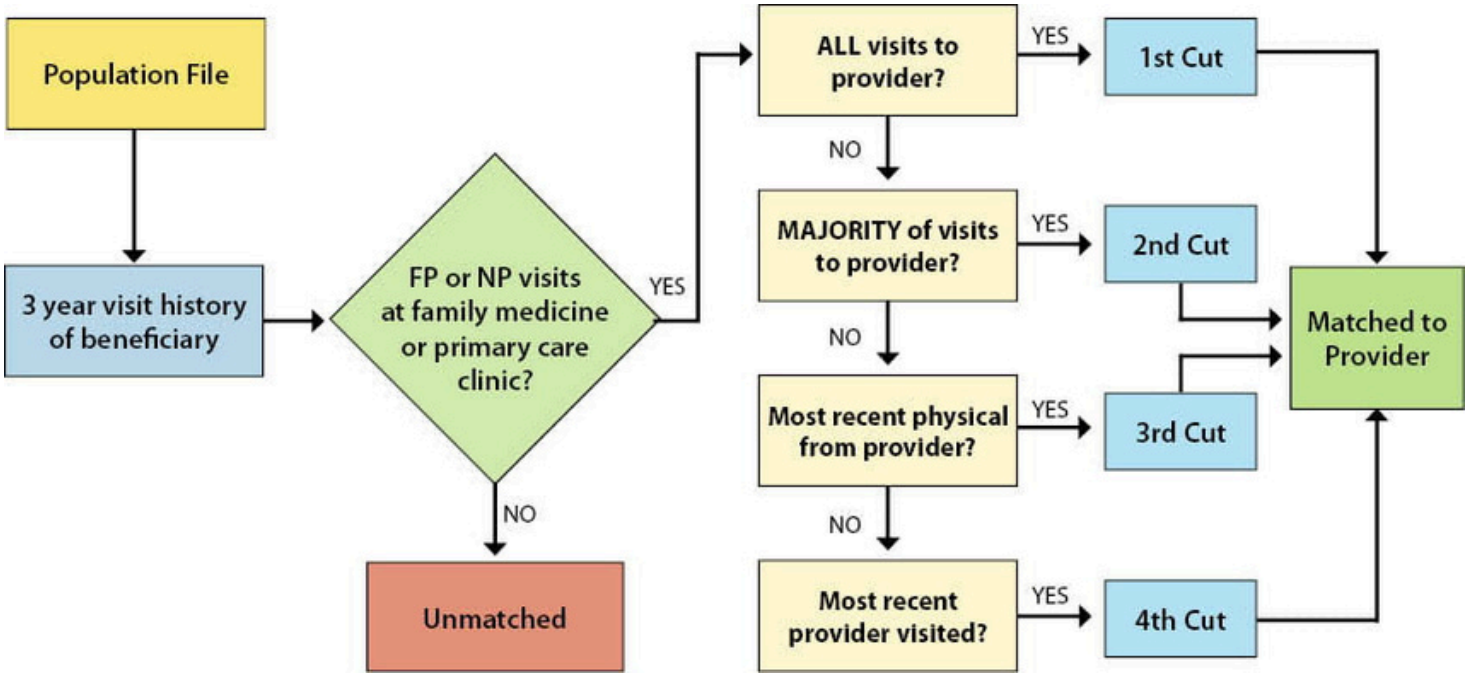
Cut 1: Saw only you. If an individual only saw you during the three years, they are matched to you. Otherwise, go to cut 2.

Cut 2: Saw you the majority of the time. If an individual saw you and other providers, but visited you the majority of the time, they are matched to you. Otherwise, go to cut 3.

Cut 3: Had their last physical examination with you. If an individual saw you and other providers the same number of times, they are matched to you if you did the last physical exam (fee codes: 3B, 4B, 52B, 64B). Otherwise, go to cut 4.

Cut 4: Saw you last. If an individual saw you and other providers the same number of times and has not had a physical, they are matched to you if they saw you last.

Figure 2.



Note: *Providers in the 4-cut method include family physicians and nurse practitioners. Patients who match to an NP will not be matched to a FP.*

CLICK HERE TO GET YOUR PANEL

TPM Payment Details

Capitation Formula

Eligible physicians will receive a payment of up to $144,000 annually ($36,000 quarterly) based on the following formula:

$$\text{Capitation Payment} = \$144{,}000 \times \left(\frac{(\text{Patient Contact Ratio} + \text{Patient Panel Ratio})}{2} \right)$$

Although each of the Patient Contact Ratio and the Patient Panel Ratio can exceed 1.0, the average of the ratios is capped at 1.0 and the Capitation Payment is capped at $144,000 (in 2024-25).

Going forward, the SMA and the Ministry will jointly review and develop patient complexity modifiers. Due to the complex nature of this methodology, there is no capacity nor intent to include payment for complexity modifiers in this model.

Offsets

Those enrolled in the TPM, will no longer receive additional payments for the Family Physician Comprehensive Care Program, Metro On-Call, and the CDM-QIP payment (i.e., specifically, the $75 payment for all indicators met per patient and per chronic condition in a 12-month period flowsheet). **FFS payments for these services will continue, as well as the requirement to complete the CDM-QIP flow sheets** (updated flow sheets coming soon).

Payment Examples

The pay model components, formulas, and details are explained in the following two examples of capitation payments:

TPM Payment Details

Real Family Physician Example 1

- Provides longitudinal full-service family medicine.
- Clinic is open 5 days per week.
- Works additional week-long shifts as a hospitalist (once every 6-8 weeks) that won't add to patient contacts or panel size.
- Longitudinal care = 5,270 patient contacts
- Panel size = 1,427

Ex. 1: Capitation Payment

$$\$144{,}000 \times \left(\frac{\frac{\text{Contacts}}{6{,}500} + \frac{\text{Panel}}{1{,}600}}{2} \right)$$

$$\$144{,}000 \times \left(\frac{\frac{5{,}270}{6{,}500} + \frac{1{,}427}{1{,}600}}{2} \right)$$

$$\$144{,}000 \times \left(\frac{0.81 + 0.89}{2} \right)$$

$$\$144{,}000 \times \left(\frac{1.70}{2} \right)$$

$$\$144{,}000 \times 0.85$$

= **$122,590**

Ex. 1: Total TPM Calculation

Usual FFS payments	**$256,915**
+ FFS increase (11.4%)	**$29,545**
~~**FPCCP & CDM**~~	
+ Capitation payment	**$122,590**
TPM =	**$409,050**

Real Family Physician Example 2

- Provides longitudinal full-service family medicine.
- Clinic is open 7 days per week.
- Works additional walk-in shifts within the same clinic during evenings and weekends.
- Longitudinal care = 7,993 patient contacts
- Panel size = 2,170

Ex. 2: Capitation Payment

$$\$144{,}000 \times \left(\frac{\frac{\text{Contacts}}{6{,}500} + \frac{\text{Panel}}{1{,}600}}{2} \right)$$

$$\$144{,}000 \times \left(\frac{\frac{7{,}993}{6{,}500} + \frac{2{,}170}{1{,}600}}{2} \right)$$

$$\$144{,}000 \times \left(\frac{1.23 + 1.36}{2} \right)$$

$$\$144{,}000 \times \left(\frac{2.59}{2} \right)$$

$$\$144{,}000 \times 1.30^{*}$$

*Ratio Capped at 1.0

= **$144,000**

Ex. 2: Total TPM Calculation

Usual FFS payments	**$394,372**
+ FFS increase (11.4%)	**$45,353**
~~**FPCCP & Metro & CDM**~~	
+ Capitation payment	**$144,000**
TPM =	**$583,725**

TPM Payment Details

Empanelment Process

An empanelment process will be developed by the SMA and the Ministry. An empanelment process requires family physicians to engage in a conversation with their patients about physician-patient empanelment and what a Most Responsible Physician (MRP) relationship between physician and patient entails.

- The empanelment process represents a physician's commitment to delivering patient-centered care by communicating and collaborating with patients regarding the management of their condition(s) and care plan(s) on an ongoing basis.
- The empanelment process means the patient commits to seeking all their primary care from that physician, or that physician's colleague(s) whenever possible.
- Physicians will be required to maintain an up-to-date list of empaneled patients and retain copies of all physician-patient documentation. The empaneled patient list will inform the next phases of the Saskatchewan-made blended capitation model.

Note: For the purposes of calculating TPM payments, the 4-cut methodology described in the payment section is used to determine patient panel size, not the number of patients the physician empanels through an empanelment process.

TPM Accountabilities & Deliverables

Longitudinal Patient Relationship

Establish a longitudinal relationship with patients, by providing ongoing family medicine services to a dedicated patient panel, which includes screening, prevention activities, chronic disease management, and comprehensive care.

Deliverables for NOW	Deliverables for LATER (as processes are developed)

• Physicians are expected to adhere to the best practices in Chronic Disease Management.
• Completion and submission of Chronic Disease Management-Quality Improvement Project (CDM-QIP) flow sheets are mandatory to ensure care aligns with approved guidelines.
  ◦ Physicians participating in TPM should submit the currently available flow sheets. Updated flow sheets will be available by July 1st, 2024.
• Physicians participating in TPM are no longer eligible for program payments under Family Physician Comprehensive Care Program (FPCCP), Metro On-Call and the CDM-QIP (specifically, the $75 payment for all indicators met per patient and per chronic condition in a 12-month period flow sheet). FFS payments for 64B through 68B services will continue.
• Physicians are expected to provide comprehensive care to their empaneled patients shared by a TPM clinic/group, including hospital and supportive care, nursing home care, pre- and post-natal and infant care, complete physicals including PAP smears, and phone calls from Allied Health Care Providers (AHCP), where applicable. FFS payments for these services will continue and will be monitored.
	• Physicians will be expected to document patient understanding and consent to the Most Responsible Physician (MRP) relationship with each empaneled patient. An empanelment process will be developed by the SMA and the Ministry:
	  ◦ Physicians will be responsible for maintaining a list of empaneled patients for whom they have accepted responsibility as the MRP, as well as retain copies of all documentation.
	  ◦ The empaneled patient list will inform the next phases of the blended capitation model and will not be used to calculate payment under TPM.
	• Physicians will be expected to adhere to a set of Primary Care Quality Indicators.
	  ◦ The Primary Care Quality Indicators will include existing CDM-QIP indicators in addition to newly developed indicators for health prevention, screening, and mental health.
	  ◦ Development of the primary care quality indicators will occur within the first six months of the implementation of the TPM.
	• Physicians will be expected to adhere to common work standards for Electronic Medical Record (EMR)/Electronic Health Record (eHR) patient-centered information exchange, as developed by the EMR Co-management Committee.
	  ◦ Work standards will include training, effective use of interoperability and improved user experience features.
	  ◦ The SMA and eHealth Saskatchewan will support physicians in this work.

TPM Accountabilities & Deliverables

Patient's Medical Home Development

Commitment to transition towards the Patient's Medical Home (PMH) framework.

Deliverables for NOW	Deliverables for LATER (as processes are developed)
• Physicians are expected to be part of a group with more than one Most Responsible Physician (MRP) participating in TPM. There must be agreement among the group to share patient information to provide coverage among providers and deliver comprehensive care within the clinic/group. Group identification should be maintained and available upon request. • For solo clinics, joining a group of physicians in the same community or catchment area is encouraged, with all physicians willing to share patient information for coverage and comprehensive care. A minimum of two-family physicians enrolled in TPM per community or catchment area is required. This will reinforce the PMH framework by aligning clinic resources, cross-covering patients, and organizing to provide a full spectrum of care. The SMA and the SHA are available to help the formation of physician groups. Please email pmh@sma.sk.ca for more information. • Appointment of at least one family physician lead from the clinic or group to be a point of contact, attend learning events, and liaise with SHA. This role is paid by the Quality and Access Fund. • Providing on-call coverage for the group's patients. Call schedules should be maintained and available upon request.	• Physician leads will participate in PMH learning opportunities, SMA's Enhanced Use Program, HQC's QI in Clinics Program, and other relevant capacity-building activities. • Physician leads will be paid by the Quality and Access Fund and identification of each lead must be available upon request.

TPM Accountabilities & Deliverables

Address Multiple Issues

Commitment to address multiple relevant patient issues/concerns during one visit.

Deliverables for NOW	Deliverables for LATER (as processes are developed)
• To ensure a patient-centered approach, physicians must reasonably address multiple patient issues in the same visit.	• The Ministry will incorporate the functionality in the claims system to submit multiple diagnostic codes per patient contact. • Once available, physicians will be expected to utilize this functionality to demonstrate the frequency of multiple patient issues being addressed in one visit.

Monitor Progress

Commitment to assist the SMA and the Ministry to achieve improvements in longitudinal community-based family medicine delivery and patient outcomes.

Deliverables for NOW	Deliverables for LATER (as processes are developed)
• TPM Physicians should request their Primary Care Panel Report from Saskatchewan Health Quality Council. • Request your individualized Primary Care Panel Report at www.bestpracticesask.ca.	• Physicians and clinics will be encouraged to enroll in related education programs for the panel reports as they become available. • Individual and clinic-level reports developed by the Ministry will be provided to physicians once available.

CLICK HERE TO GET YOUR PANEL

New to Practice Graduates & New to Province Family Physicians

FFS family physicians without a patient panel are welcome to participate in TPM. They could be a new graduate who is new to practice, or a family physician who is new to Saskatchewan. In these circumstances, some time is required to build a patient panel and would negatively affect the capitation payment. For this reason, new graduates new to practice or family physicians new to the province will be given a proxy patient panel for the first two years of practice, while growing their own panel. The proxy patient panel will be determined by their number of patient contacts to inform the panel size in the capitation payment formula. The panel proxies are listed below.

Range of Patient Contacts (Annual)	Proxy Patient Panel Year 1	Proxy Patient Panel Year 2
0 - 749	0	0
750 - 1,999	640	715
2,000 - 2,999	745	830
3,000 - 3,999	850	950
4,000 - 4,999	980	1,095
5,000+	1,065	1,190

Longitudinal care = 3,000 patient contacts
Proxy panel size = 850

Ex. 3: Capitation Payment - Year 1

$$\$144{,}000 \times \left(\frac{\frac{\text{Contacts}}{6{,}500} + \frac{\text{Panel}}{1{,}600}}{2} \right)$$

$$\$144{,}000 \times \left(\frac{\frac{3{,}000}{6{,}500} + \frac{850}{1{,}600}}{2} \right)$$

$$\$144{,}000 \times \left(\frac{0.46 + 0.53}{2} \right)$$

$$\$144{,}000 \times \left(\frac{0.99}{2} \right)$$

$$\$144{,}000 \times 0.50$$

= $72,000

Estimated FFS payments $180,000
+ Capitation payment $72,000

New to Practice/ Province TPM = $252,000

NEW GRADUATES ARE ELIGIBLE TO APPLY NOW!

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Innovation Fund to Enable Team-Based Care

Separate from TPM, a **$10 million** annual fund was established to enable family physician-led, team-based care, beginning in 2024.

The intent of the Innovation Fund is to encourage the development of family physician-led approaches for improving access to team-based care in community-based family medicine clinics, based on the unique circumstances of the clinic and its patients and in alignment with the Patient's Medical Home framework and Health Networks.

- A committee of SMA family physicians and Ministry representatives has been initiated, with advisory representatives from the SHA (for health network alignment) to design the process, and review and approve proposals. This committee is leveraging the existing membership of the Primary Care Compensation Working Group.
- Proposals may include costs for:
  - Structured support to physicians and clinics in the transition to family physician-led, team-based care.
  - Physicians or clinics to employ office staff and/or non-physician providers, including associated incremental business expenses such as rent, equipment/IT/EMR costs, and HR costs.
- All family medicine clinics will be eligible, but priority will be given to community-based longitudinal family medicine clinics that have enrolled in the Transitional Payment Model.

Questions?

For questions about TPM or the Innovation Fund, email SMA:

pmh@sma.sk.ca

For questions for the Ministry's TPM administration team, email:

tpm@health.gov.sk.ca

Frequently Asked Questions about TPM

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